

THE
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**CANADIAN
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**OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL**

JULY, 1948

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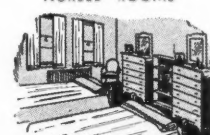
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DINING ROOMS



LINENS

NURSES' ROOMS



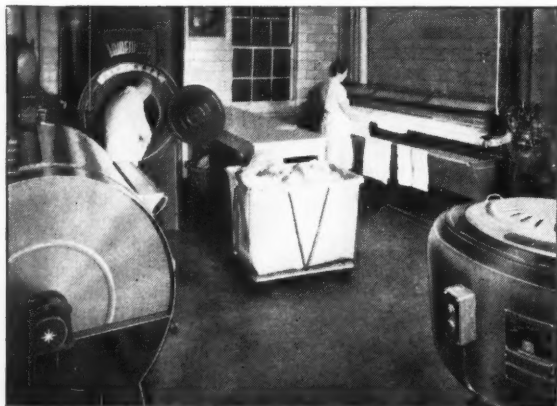
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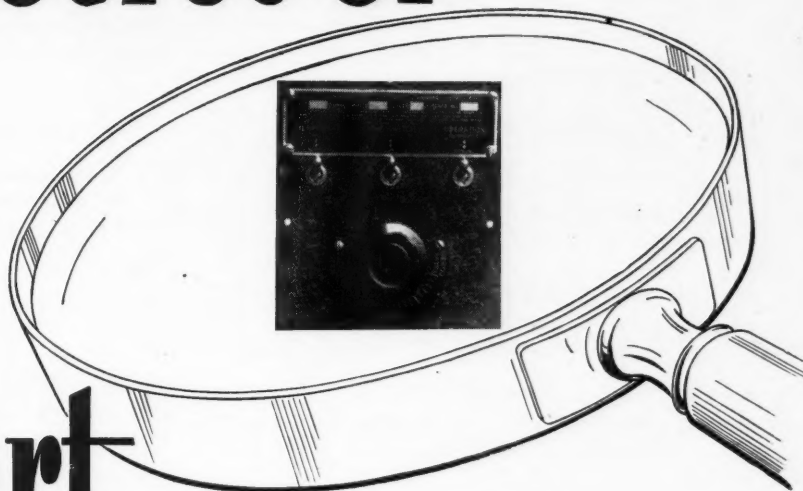
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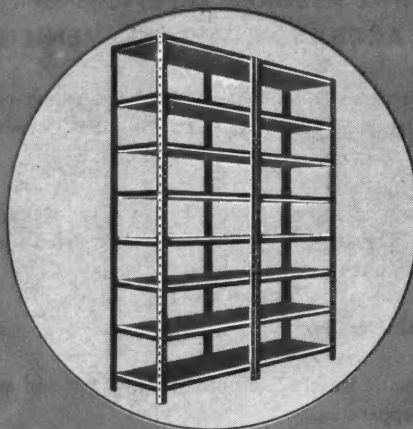
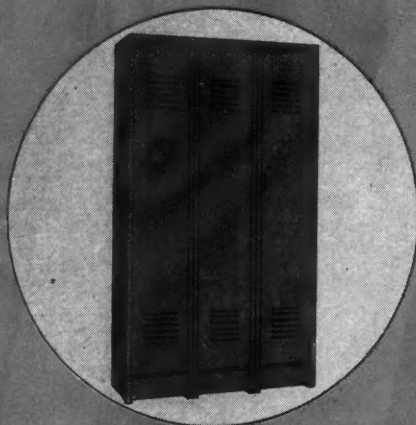
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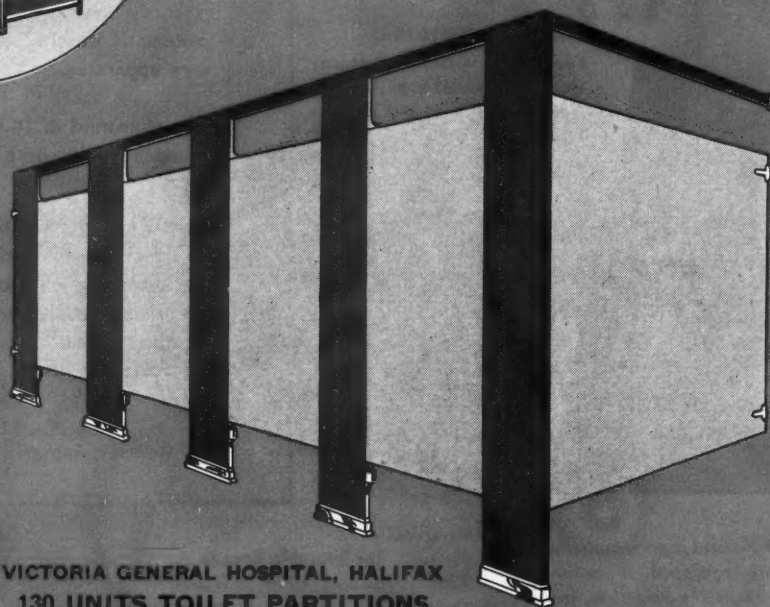
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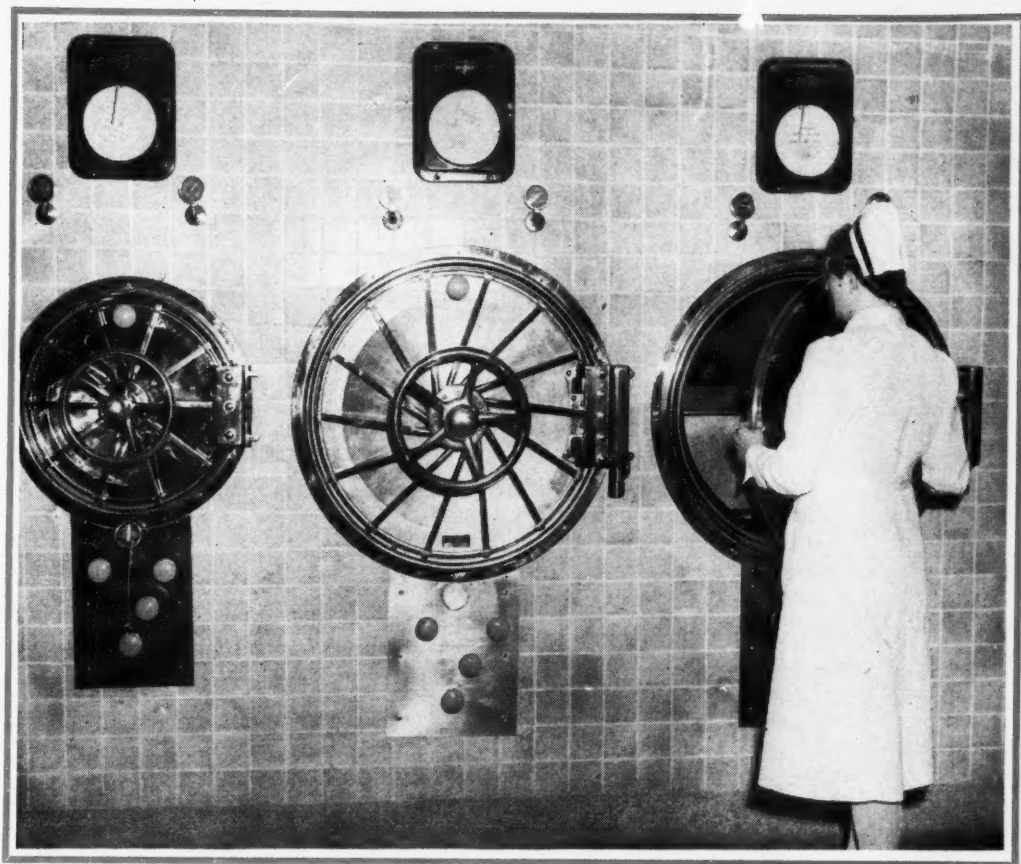
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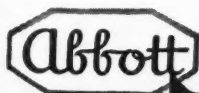
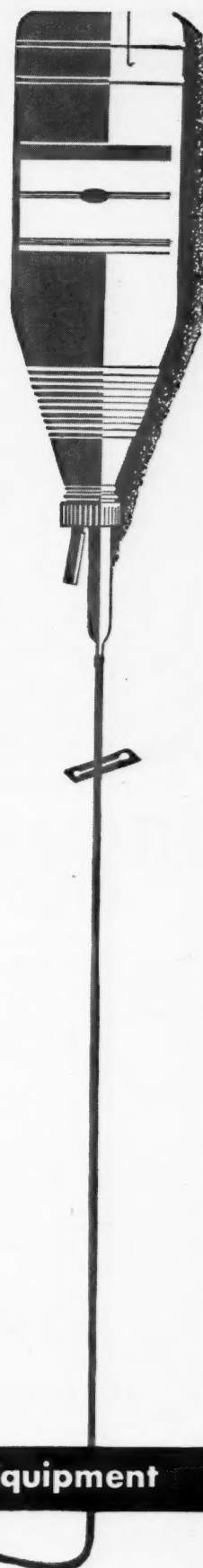
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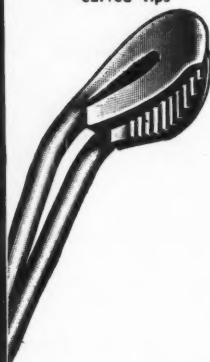


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Across the Desk

By C.A.E.

Electro-Vox Sound Equipment

Electro-Vox Inc., Montreal, have issued an attractive and very useful booklet on the varied uses of their sound equipment.

System A, Centralized Sound System. The main purpose of this Electro-Vox system is to transmit entertainment programmes to hospital patients and also, during their leisure hours, to the staff. There is a selection of Electro-Vox receiving sets: (a) loud-speakers that may be adapted to ceilings or walls in solarium, rest-rooms, dining rooms and, whose size and volume are specially designed to provide pleasant broadcasting; (b) pillow-speakers or mono-phones that enable the patient to choose a programme without disturbing or being disturbed, if the room is for two or more occupants. These sets include a small case, very easy to handle and which the patient may hold, containing a programme selector and a volume control. The patient is therefore spared all unnecessary movement.

System B provides voice communication—Nurse v. Patient. This Electro-Vox system, operating in conjunction with the light-signal, is to enable low-voiced conversation between the nurse and the patients. It consists of a combination microphone-speaker at each end of the installation, operated by means of selector keys corresponding to each individual station. Only the nurse operates the controls.

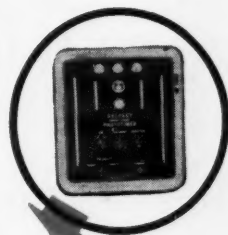
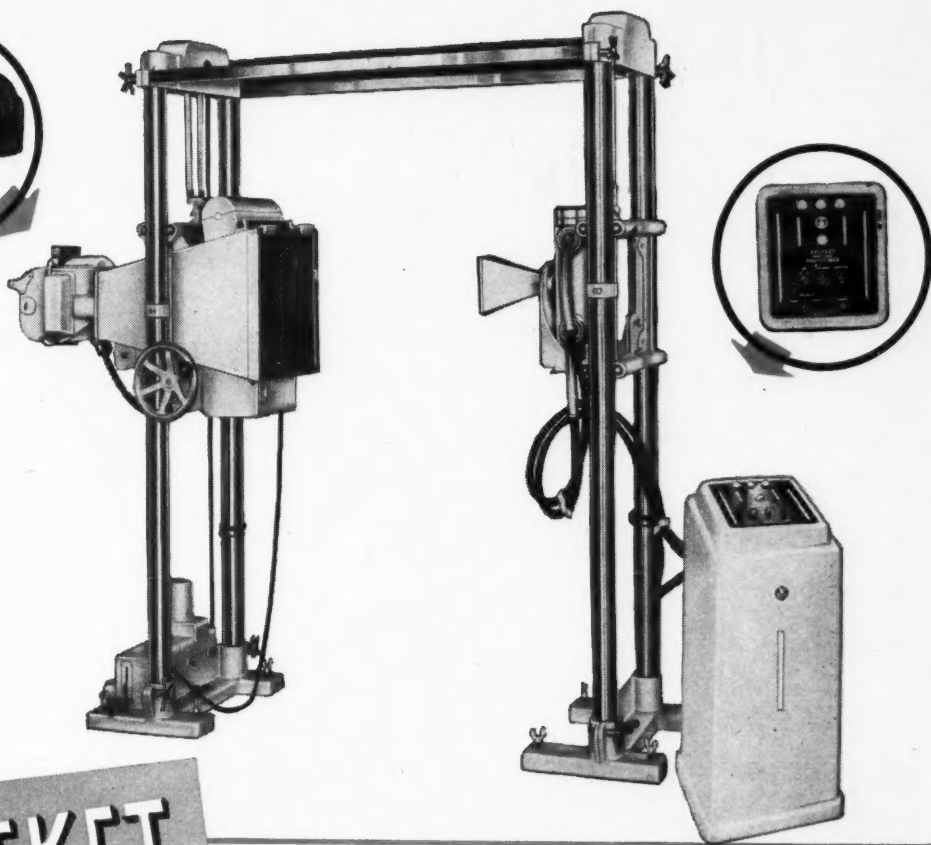
System C is for paging doctors and staff. With this system, one may automatically page doctors and members of the staff throughout the hospital. It is composed of a number of small low-level speakers installed at nurses' duty desks, in doctors' offices and in the staff's rest rooms, dining halls, etc.

System D, Diet and Main Kitchen voice communication. It ensures a direct and quick two-way voice communication of the departments concerned with the ordering, preparing and delivery of food throughout the hospital. Apart from being able to converse selectively, the main kitchen, diet kitchen and food elevators are also in direct communication with the various wards.

System E ensures a direct and immediate two-way communication between the main pharmacy stock room, dispensaries, laboratories and operating room. This system frees the telephone, at the same time hastens the service, and in all respects is far more efficient.

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(Continued on page 16)



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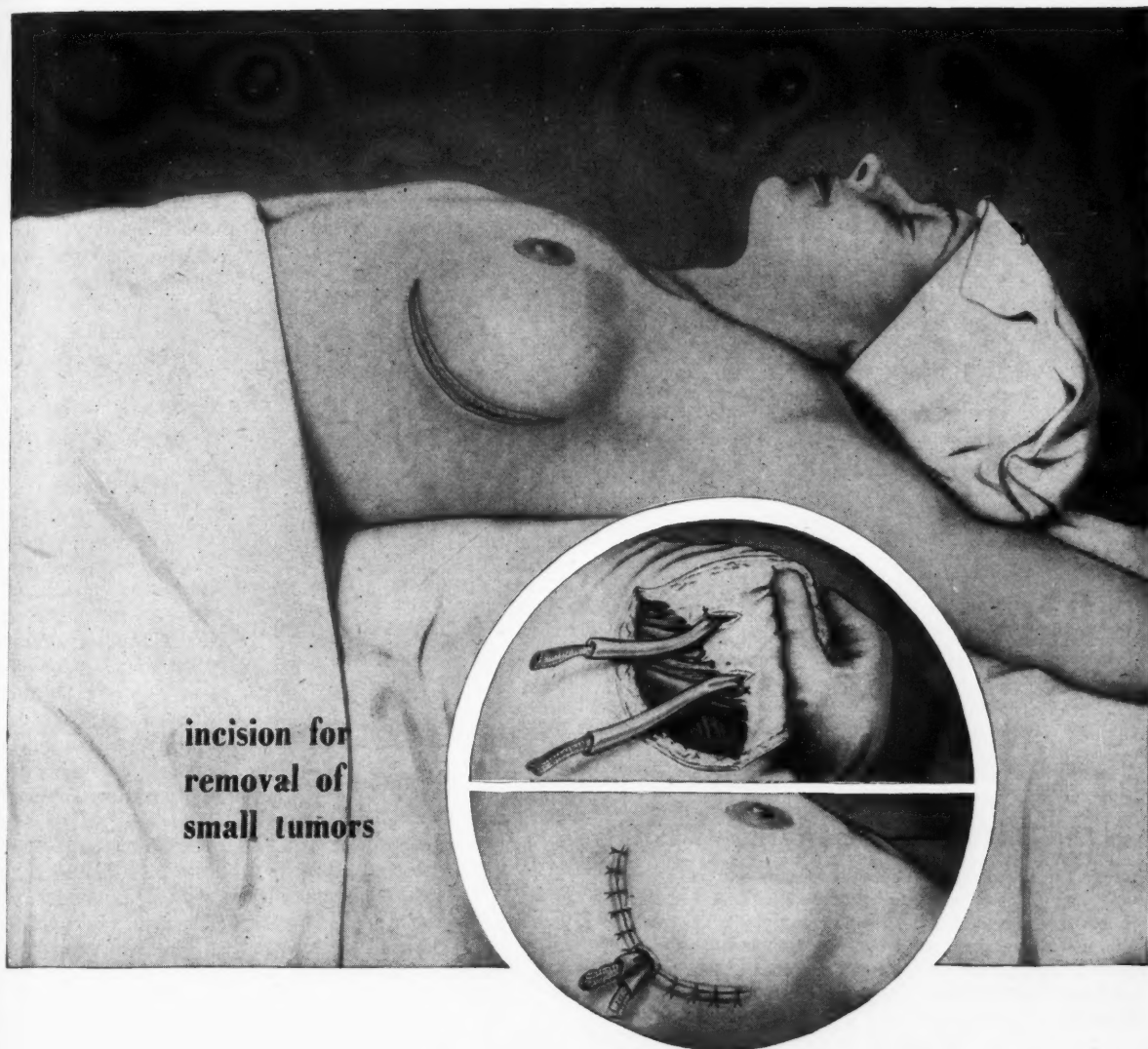
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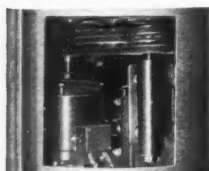
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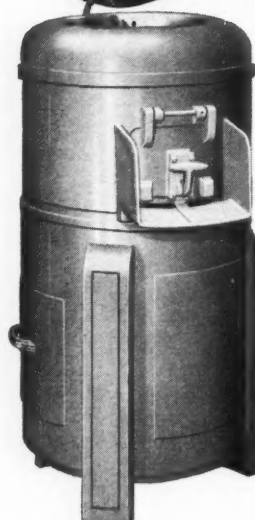
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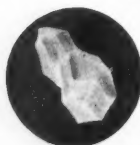
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Across the Desk

(Continued from page 12)

J. I. Robinson Elected President Crane Limited

At the Annual Meeting held recently, James Irwin Robinson, hitherto Vice-President and General Manager, was elected President of Crane Limited.

Mr. Robinson's accession to the new post climaxes forty-one years of service with the Crane organization.

A Canadian, he was born on a farm near Prescott, Ontario, and was educated at Prescott High School and Ottawa Business College. In 1907 he started with Crane Co., in San Francisco, subsequently becoming a salesman for that branch. During World War I, he returned to Canada and served with the Canadian Engineers until 1919, whereupon he was given the position of Sales Manager with Crane Limited whose Canadian valve and fitting factory



went into operation the same year. Shortly afterwards, he became General Manager of Sales for Canada, and in 1927, was elected a director, and during a period from 1932 to 1934, built up the Company's western industrial connections as branch manager of the Vancouver office. Following his return to Montreal, he was appointed Vice-President and General Manager in 1937.

* * * *

"Wycillin" Is New Wyeth "Aqueous" Penicillin

A new form of injectible penicillin, which will greatly simplify its use by the medical profession and make it much more widely available in fighting pneumonia, venereal diseases and other bacterial maladies, was announced recently by John Wyeth & Bro. (Canada) Ltd., pharmaceutical manufacturers. The new product, it is claimed, is likely to obsolete other earlier forms of the war-born wonder anti-biotic drug because it can be carried around safely in a physician's pocket, and in aqueous solution retains its potency for as much as seven days without refrigeration.

The new Wyeth product is technically termed Crystalline Procaine Penicillin G for Aqueous Injection, and it will eliminate the pain associated with the injection of earlier forms of penicillin, and also will obviate the danger of embolisms which have resulted in some cases from the injection of oil-and-wax and oil suspension forms of the drug used widely up to this time.

Wycillin is a procaine penicillin which when suspended in sterile distilled water and injected into the muscles of a patient, will maintain effective blood levels for twenty-four hours.

(Continued on page 20)

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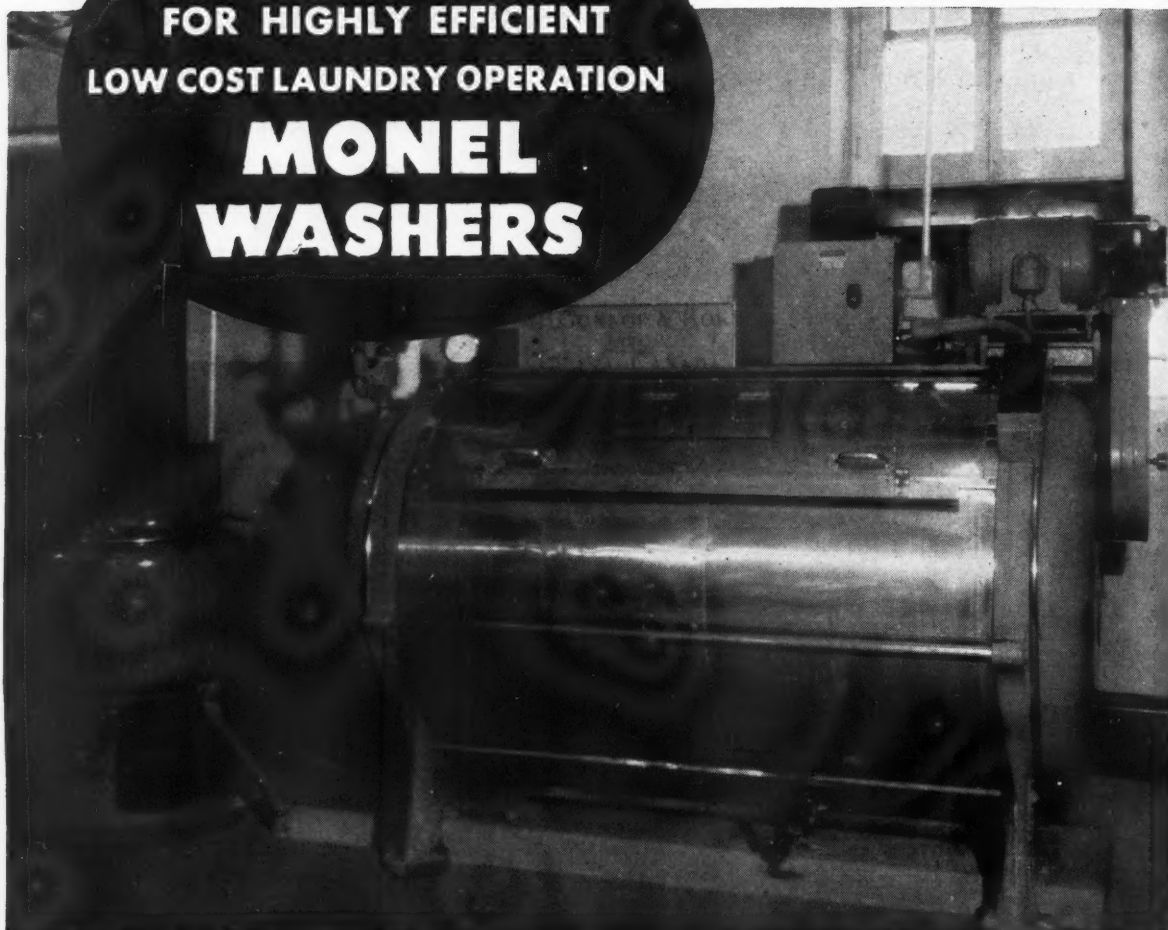


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Across the Desk

(Concluded from page 16)

Delegates and Exhibitors Enjoy Maritime Convention

At the Maritime Convention last month the exhibitors were very much a part of the hospital gathering. They were welcomed by the President, Dr. J. A. Clark, and a resolution was passed thanking them for their share in making the meeting a success. The Algonquin Hotel has ideal space for exhibits and at all times delegates could be found sauntering among the attractively arranged booths. In fact, we understand that a very considerable amount of business was transacted during those few days.

Suppliers' representatives were ready at all times to be helpful—they provided cars to drive delegates to St. Stephens and even helped serve the tea, as well as arranging the laugh-a-minute entertainment which followed the annual dinner. The motion picture, Walt Disney style, was shown through the courtesy of Johnson and Johnson, while Alex. McGovern of Ferranti Ltd., rolled 'em in the aisles with his comic portrayal of a typical day in the life of a hospital administrator. To Alex. also goes credit for the highly edifying news sheet which appeared at the dinner table each night. Few people escaped his penetrating wit and all products on display were given a boost in one issue or another. The sheet was duplicated on the floor through the co-operation of the Multigraph Sales Agency. It was clever work. —J.F.

* * * *

Science in Food Preservation

Food technology has taken the mystery out of food preservation and now offers possibilities of new methods which may revolutionize the food processing industry within the next 20 years, H. N. Riley, Vice President in charge of Research and Manufacturing of H. J. Heinz Company, Pittsburgh, stated at the annual convention of the Institute of Food Technologists in Philadelphia.

Speaking of some of the functions of the research and quality control scientists, Mr. Riley pointed out, "In the case of raw materials it is necessary to understand what variations are apt to occur under certain conditions and to establish the characteristics of greatest significance for the use to which it is to be put.

"Containers are another important field, whether they be metal or glass. The war years particularly enlivened this area with the development of electrolytic tinplate and various substitute lacquers and enamels.

"The processing of the packaged product to insure its keeping is almost entirely the responsibility of the scientist in the quality control department and he is also interested in the storage of finished products, as these storage conditions have much to do with the quality of the product as it reaches the consumer."

* * * *

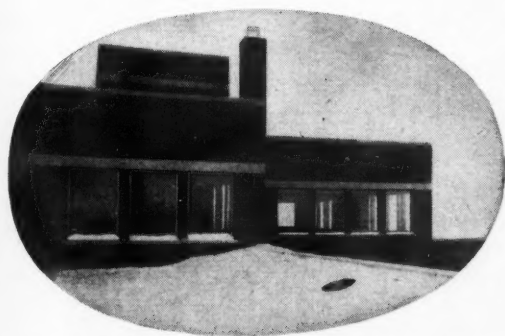
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Twindow opens walls to cheerful sunlight; brings outdoor life and activity inside; keeps patients in the happy frame of mind so important during the convalescent stage.

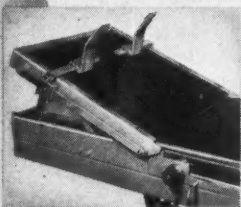
Besides the therapeutic and psychological benefits of Twindow, patients enjoy greater physical comfort throughout the year. Even in coldest weather, rooms are warm *right up to the panes!* Loss of heat is reduced; 'fogging up' is virtually eliminated.

For further information about Twindow consult your architect or write Hobbs Glass Limited, London, Canada.

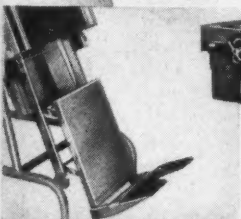
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for glass!**



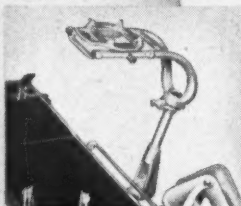
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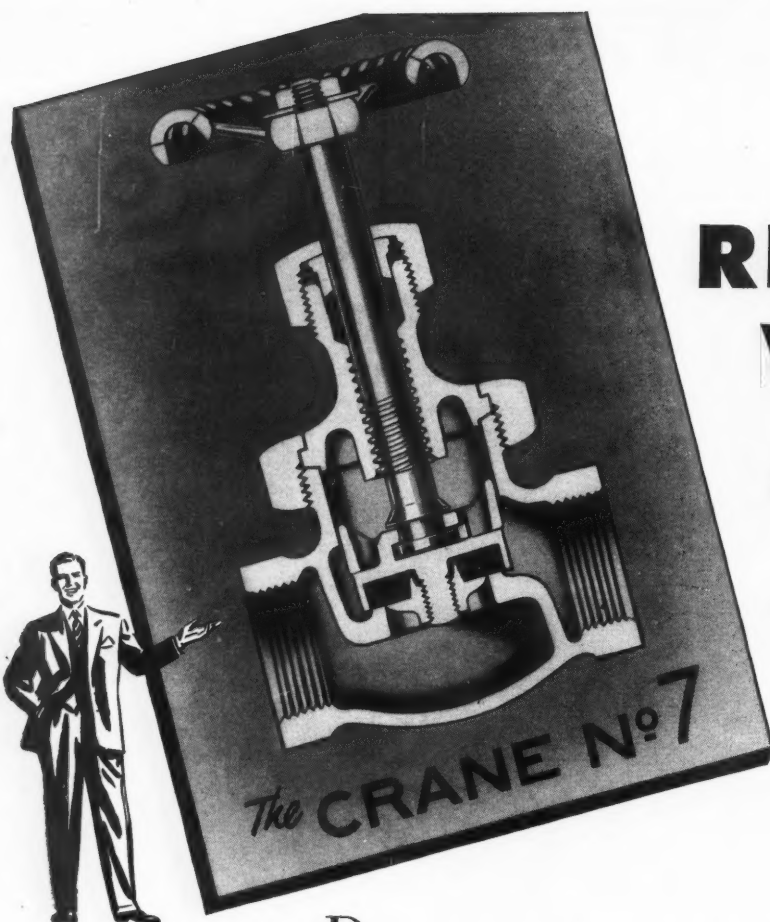
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CANADIAN HOSPITAL

Harvey Agnew, M.D., Editor

Toronto, July, 1948

Vol. 25

No. 7

Obiter Dicta

A Surgeon Speaks Out

DR. W. E. GALLIE, leading Canadian surgeon and past-president of the American College of Surgeons, has come out very strongly in favour of a two-year basic course in nursing. This would be for bedside nursing and could be supplemented by special training for such specific fields as surgical, medical, paediatric, or psychiatric nursing. This plan, in his opinion, would lessen the amount of the various types of specialized work done by the student nurse, training which would not be essential for a particular branch of specialized work later. If desired, it could be taken up as post-graduate study. There is much evidence that this viewpoint is widely held in the medical profession which is not directly concerned with the economics of nurse-training.

To relieve the present shortage, Dr. Gallie has other suggestions. He supports group nursing, an arrangement now being followed in various centres and similar to the group nursing tried out during the depression, although for a different reason at that time. He deplored the employment of nurses as airline hostesses (a practice limited to Canadian lines) and risked the ire of his colleagues by deploring the employment of nurses in doctors' offices. The problem here is that some of these duties do require a nurse's training, although much of the work could be done just as well by an office worker or a technician. This may be another argument in favour of the grouping of practices to permit the employment, by the group, of stenographers, technicians, and nurses.

In placing responsibility on the nurses for solving the present shortage, Dr. Gallie is risking a few irate phone calls. He is on sound ground in stating that they know most about the problem and that we need their help and leadership. It is questionable, however, if we can expect them to solve this riddle alone, and with this Dr. Gallie will probably agree. Were they like some organized trades, which have cut down apprenticeships to maintain short supply or have imposed restrictions on outside groups doing any of their work, we would have a real grievance; but the nurses have not followed these dubious

methods. They have tried desperately to augment their number, have approved courses for nursing assistants, have supported group nursing, have discouraged emigration (not too strenuously), have been reasonable in salary demands, and have not tried to prevent practical nurses and others from nursing for hire. We have already stressed that it cannot be held the responsibility of 179 hospitals to go on training endless classes of nurses to depart immediately for industrial jobs, public health, D.V.A., T.C.A., the United States, or the altar. With the new federal health proposals there is now a chance that the obvious necessity for solving this problem—and soon—will make us realize that the solution is the responsibility of all of us, and that neither the nurses nor the hospitals can achieve it alone.



Britain Drops Means Test

ONE of the changes instituted in Great Britain on July 5 was a considerable modification of the means test. This is but one of several social and health enactments effective that day and is a fundamental departure from the traditional basis of determining indigency status. A national assistance board is being set up to deal with unemployment assistance, outdoor relief, supplementary pensions, blind assistance, and tuberculosis treatment allowances. There will be no household means tests and the resources and the requirements of applicants will be considered jointly. The incomes of sons and daughters will not be taken into account. The first £375 (\$1500) of war savings will be ignored as will also other capital to the amount of £75. If £75 or over, but not more than \$400, weekly assistance will be reduced by 6d. for the first £75 and 6d. for each additional £25.

This is a much more sensible procedure than the one followed here where, in so many instances, a municipality may refuse to consider a person indigent because of some equity in property—equity which could not be realized without considerable loss. The means test, although

seemingly justified, actually has penalized the thrifty poor who have been denied assistance because they had invested their small savings in a home instead of squandering it on liquor or the bookie. One dubious angle to our ever-spreading floor of social security and protection is the tendency to pauperize the large stratum of society which would delight in that experience. So many influences today, social and legislative, discourage any measure of thrift, thus swelling the ranks of those who will support any wildcat scheme that will promise them something which they have not earned. This action of the government would seem sound.



Methods of Optical Houses

HARD on the heels of the investigation of dental supply houses for price-fixing comes a report from Mr. Fred A. McGregor, commissioner of the Combines Investigation Act, charging that the optical goods industry has had an elaborate price-fixing system. It is stated that there has been a drastic curtailment of price competition in spectacles and that some twenty-five or more well-known companies are involved. It is stated, too, that in 1946 more than 90 per cent of all optical goods supplied to retailers and to consumers was affected. Firms specifically named include the American Optical, its Canadian subsidiary, the Consolidated Optical, Imperial Optical, Bausch and Lomb, and Numont Ful-Vue. The Central Optical Co. of Montreal (acquired by Bausch and Lomb in 1944) was credited with having resisted the price-fixing licensing system in the early stages, but had to capitulate in order to get supplies. Apparently results were achieved by licensing manufacturers, wholesalers and retailers, and by setting up minimum prices at each stage. By regional and national agreements, low-priced lenses were withdrawn from the market. Figures quoted in the press indicate the tremendous present spread between the wholesale price to opticians and optometrists, even though greatly inflated over pre-war figures, and the minimum charge that must be made to the customer. Again the consumer is the sufferer and, as in the case of the recent price spreads investigation little may be done about it.

Of interest to hospital people, too, is the statement that many doctors get "rebates" from certain wholesale and retail opticians. Methods of arriving at the proportion of the retail price paid to the doctor vary considerably. In some cases the doctor may receive only a flat sum of \$5 per patient; more commonly he receives that part of the retail price left after the wholesale prescription price of the glasses and a "fitting fee" of \$1, \$2, or \$3 are deducted. These payments were estimated to total in 1946 some \$500,000. We know that leading ophthalmologists decry this practice as unethical and do not accept rebates, but we are informed that there are still quite a number of doctors, not all of whom are eye-specialists, who do. There has been so much ado about fee-splitting in surgery that we have often wondered why medical organizations, including medical staffs, have done so little about this practice. Perhaps there is a feeling that this practice is dying out, like the old custom fifty or more years ago of accepting rebates from the

druggist and the not-so-old custom of kick-backs from the undertaker. We are informed that fee-splitting, which is still fairly prevalent in some areas, has caused some interesting income tax tangles, for the surgeon, in self-defence, has had to report these splits as "expenses" and the recipient apparently doesn't always enter them. Undoubtedly the income tax department has been deeply interested in this last report.

There may be some room for argument as to the extent to which price-fixing, rebates, and commissions can be practised in business without trespassing on sound principles or the public interest, but, in a profession like medicine, or in vocations rendering somewhat allied services to mankind, such as optometry, there should be no ground for suspicion that advice given might be coloured by a financial motive.



Complaints Adequately Handled in British Voluntary Hospitals

IN the letter by "Londoner" in our March issue (page 58) Mr. Bedwell referred to the matter of holding enquiries into any misadventure occurring to patients and indicated that the machinery for handling these situations is better in the municipal than in the voluntary hospitals. Conduct of municipal hospitals may be questioned in open council but "there is no such way of protecting the interests of patients in voluntary hospitals" where there is a tendency to hush up matters in case damage is done to the reputation of the hospital.

The Secretary of the British Hospitals Association has indicated in a forceful letter his "complete disagreement with 'Londoner's' statement for which (he knew) of no justification and which, unless corrected, might create a seriously erroneous impression". Mr. Wetenhall points out that the general practice is to treat complaints very seriously and sympathetically. Those trade unions which have had most to do with hospitals have paid tribute to the general system of management in voluntary hospitals; in fact their attention to complaints has been more efficient, prompt and satisfactory than has been the case in some other spheres.

It was kind of Mr. Wetenhall to make certain that no false impressions would be left on this point. Being closer to the situation, he has probably read more into this comment than we have taken from it here. It would seem logical for Mr. Bedwell to note that publicly-owned institutions are subject to more open supervision by the public than are voluntary ones; that is a general observation everywhere. This "protection" of the public has often created most unfortunate publicity here, publicity which has been highly damaging to an innocent and well-run institution. One can well understand the desire of institutions to avoid publicity at times, even though present day public relations thinking encourages hospitals to be the first to give news to the press and so ensure accuracy of reporting and a reputation for fair dealing. It would seem that, in the heat of debate over the new control of hospitals, certain aspects of the situation have assumed undue proportions in the minds of the public and of the legislators.

Psychosomatic Principles

—Their Application to Care in a General Hospital

THE word "psychosomatic" does not describe a new specialty, a new science or even a new concept, but rather a shift in emphasis. This shift is from the emphasis on illness as a breakdown of the machinery of the body to illness as unsatisfactory performance of the human organism. It follows psychobiology as a study of the reactions of the total individual in his environmental setting.

First Principle

Psychosomatic principles are not yet fully accepted in medical circles and, consequently, it is not to be expected that their implications have been fully realized in hospital administration. The first of the psychosomatic principles is that

in illness therapy has to be directed toward the treatment of the patient as a person with all his personal attributes and functions.

I cannot speak with any authority on hospital history, but as far as I know, the Temples of Aesculapius were the last medical centre where an attempt was made to treat the total individual. In the modern era, strange as it may seem, this truly general function of a hospital was first recognized, not in general hospitals, but in mental hospitals. The first co-ordinated attempts in general hospitals to fulfil this function were made in service hospitals during World War II, although some aspects of a broad program had been introduced in convalescent hospitals in World War I.

Treatment of the patient as a person involves a consideration of his personal problems, his social adjustment and his emotional state, as well as his physical reactions. This study

B. H. McNeel, M.D., D.Psych.,
London, Ontario.

is within the ill-defined field of psychiatry. It seems scarcely necessary to insist that psychiatry has a role in the general hospital; all the best books say so. However, if authority is needed, I would refer you to sections 82-86 of the report of the Commission on Hospital Care of the American Hospital Association. The report recommends that the general hospital should have facilities for the diagnosis and treatment of mental diseases.

There may be some who will take this to mean the conditions known as the psychoses. It is a very popular idea among general hospital staffs that psychotic patients must necessarily be treated in mental hospitals. However, as has been frequently pointed out, the general hospital has a real responsibility to treat such cases as deliria arising as complications of infections, toxic conditions, trauma (accidental or surgical) and metabolic disorders. I have frequently seen acutely disturbed patients suffering from pernicious anaemia, hyperthyroidism, postpartum, psychosis, or bromide intoxication, recover quickly in general hospitals with adequate treatment. Deliria are not the only complications arising in patients who have been admitted to hospital for physical disorders. Apprehension regarding treatment, fear of death or prolonged convalescence, anxiety regarding subsequent disability, and addiction to sedatives or narcotics, are psychological complications which may accompany medical, surgical, or other physical treatment.

Second Principle

The second psychosomatic principle is that

mental and emotional disturbances may give rise to physical disturbances.

Patients suffering from such conditions come to the doctor or the hospital complaining of physical distress, rather than personal troubles. Billings states that of the patients admitted to the medical wards of the Colorado General Hospital, one in thirteen "present personality disorders which not only account for his complaints but which are fundamentally approachable from the psychiatric point of view". Reports from other centres indicate that this is not a situation peculiar to Colorado. One might go even further to say that all patients to a greater or less degree are helped toward recovery or are affected adversely by their emotional state and by environmental factors.

The importance of these considerations to the hospital administrator is simply this: If the patient with a psychosomatic illness is not appropriately treated, not only has the hospital not given adequate service but it is likely to incur unnecessary expense due to prolonged stay in hospital, and to needless, repeated investigations of various sorts. The bulging envelopes of x-ray films on some of these patients are ample testimony of wasted expenditures of time, effort and money.

Third Principle

A third principle is that

return to full health and efficiency requires adequate motivation.

A discussion with a chronic or slowly convalescing patient will frequently bring to light an extremely discouraging life situation. For a return to health such a patient requires either to have the situation modified so that he can cope with it, or to gain a new perspective and a new appreciation of the internal and external resources at his disposal through psychotherapy or spiritual guidance. Many situations cannot be remedied, but many others might be ameliorated sufficiently to make discharge from hospital reasonably

Address, London Institute for Hospital Administrators, April, 1948.

Dr. McNeel is Consultant Psychiatrist for the Ontario Department of Health, London area, and Consulting Psychiatrist, Victoria Hospital, London.

attractive. The only way that a hospital can cope with such a problem is through a competent social service worker who will be able to work effectively with relatives, employers, and others.

Fourth Principle

A fourth principle is that full health is often regained only through practice and the experience of well-being.

This has both a physical and a mental aspect. For a really sustained sense of well-being, minds and bodies require employment. It seems strange that the surgeons are concerning themselves so much with the role of activity in restoring the function of "the part", while the rest of us ignore the importance of activity in restoring the function of "the whole". How often it is necessary to explain to a patient complaining of weakness and fatigability in convalescence that, if a perfectly healthy man were to be kept in bed for three weeks, he would reach the same state!

Fifth Principle

The last principle I will mention applies to the true psychosomatic or psychogenic cases, and it is that

the cure in many of these cases depends on emotional re-education, learning to deal with life experiences in a different way.

In a hospital this may be effected to a certain degree—in some instances by the kind of experiences which the patient has in the hospital. Some people require kindly discipline, some require understanding, some require explanation, some require reassurance. The only way such therapeutic influences can be provided is by achieving an indoctrination (one might say inspiration) of the ward staff. There is such a thing as *morale* in a hospital as well as in an army unit.

Practical Arrangements

The foregoing discussion has indicated two main objectives of treatment from the "psychosomatic" standpoint:

(1) To provide adequate treatment for delirious patients and for non-delirious patients in whom emotional disturbances are significant causes or complications of illness;

(2) To improve the treatment and speed the convalescence of all patients



Toronto Western Hospital Honours Pioneer Nurses

On the occasion of the golden jubilee of the training school of the Toronto Western Hospital, Miss Beatrice L. Ellis and the late Miss Georgie L. Rowan, were honoured for their outstanding service in the field of nursing. In a fitting ceremony, the portrait of Miss Ellis, who for 25 years was superintendent of nurses and head of the training school, was unveiled by the first student nurse, now Mrs. I. P. MacConnell. Mrs. C. J. Currie, superintendent of Grace Hospital from 1901 to 1908, unveiled the portrait

of Miss Rowan, who was later superintendent of that hospital and who joined the staff of Toronto Western as director of nursing on the private wards when it amalgamated with Grace Hospital in 1925 and retired with Miss Ellis in 1943.

In the above picture, A. J. Swanson, superintendent of the Toronto Western, looks on while Mrs. I. P. MacConnell receives flowers from Elsie Green, who is wearing a reproduction of the costume worn by Mrs. MacConnell as a student.

ents by the employment of general measures to promote *morale* and good emotional adjustment.

If such objectives are accepted as reasonable goals of general hospital care, certain facilities will have to be provided which are not at present available in our general hospitals. It is apparent that the achievement of the first objective mentioned depends on the provision of bed space, treatment facilities and personnel trained in dealing with such cases. What is required to attain the second objective may not be so obvious.

Treatment Program

At the risk of sounding too

idealistic and too far removed from the hard cold facts of administration, one would like to say that what is required is a *policy of treatment* and a *treatment program*. The general hospital might do well to copy and modify to its own requirements the various programs employed during the war in the service hospitals. These were group programs which aimed to get the patients up and functioning and consisted of graded activities suited to the requirements of the various classes of patients. As each individual was fitted into the program, his capacities and needs were taken into account and an at-

(Continued on page 80)

Halifax Proud of New

Victoria General Hospital



IT was most fitting that the new Victoria General Hospital, Halifax, Nova Scotia, should be opened on the 24th of May, for the original hospital was named after Queen Victoria in 1887, in honour of the golden jubilee of that Sovereign. In the rotunda of the new structure there is a special portrait of her which was procured from Buckingham Palace.

Begun in 1944, the hospital is fifteen storeys high in gradually receding dimensions, and is built on architectural lines which are in keeping with the spaciousness of the site and the surrounding buildings. At the opening ceremony, Hon. Merrill D. Rawding, Public Works Minister, handed a golden key to Hon. Frank R. Davis, Minister of Health, thus symbolizing the turning over of the completed hospital to the Department of Health which is to operate it.

The massive stone and brick structure has the general floor outline of an aeroplane—a central rotunda with three wings extending north, south, and west. Special care has been taken both in lay-out and decoration, to give the hospital an atmosphere of homelike comfort and tranquility.

Wards and Rooms

Of the total capacity of 400 beds, the 250 public ward beds are divided into 10- and 12-bed wards on the

fourth, fifth and sixth floors. The seventh and eighth floors contain 80 private rooms and 70 semi-private. To avoid monotonous uniformity, the wards have been kept small, some of them being angular in shape. No adjoining wards are decorated the same, a variety of pastel tones having been used with matching floral drapes. Bed spreads and slip covers blend in colour with the wall tones.

The curtains around each bed are one of the features of the wards. These can be pulled easily and noiselessly, thus ensuring privacy for the patient. At the end of each floor is a large glass-enclosed solarium. Here the hangings are in gay colours and the reclining easy chairs and writing desks add to the comfort of the ambulant patient.

In the wards and semi-private sections there are also "quiet rooms" for patients whose conditions require segregation. These rooms are separated from the wards by glass panels, permitting staff members to keep patients under observation at all times.

Operating and X-ray Units

The x-ray unit is located on the third storey of the west wing and contains the most up-to-date equipment. In the north wing is the physiotherapy and occupational therapy department.

On the twelfth floor there are five

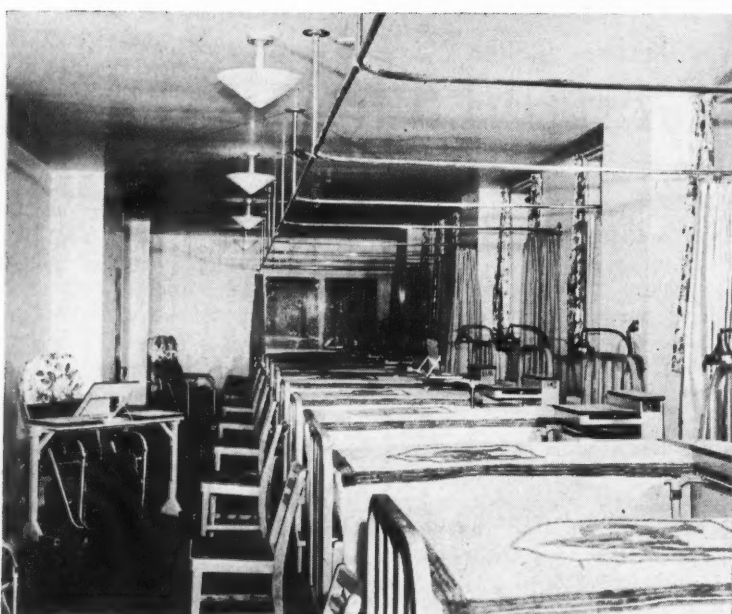
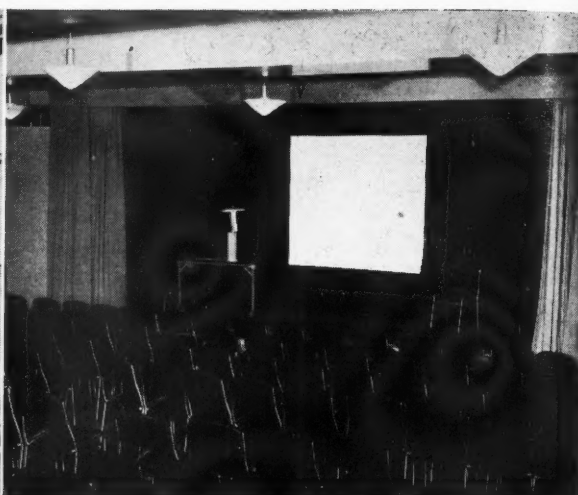
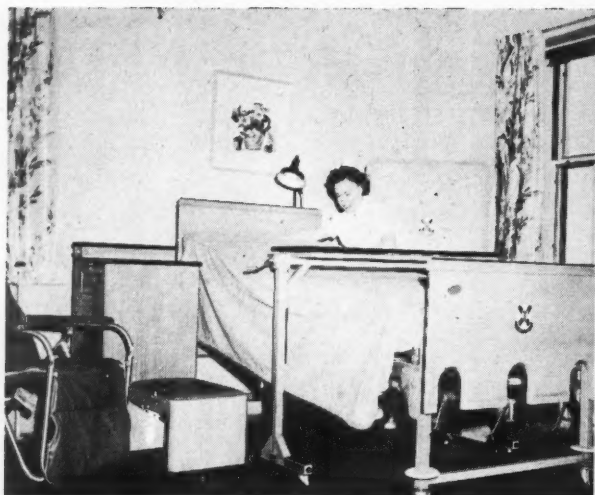
general operating rooms and three for specialized surgery. Two of the rooms have glass-fronted galleries for students, reached by separate doors and stairways. A two-way communication system between the galleries and the operating rooms permits an accompanying description to be given during the course of an operation.

As an added protection against entry of impure air of varying temperature, operating rooms are without windows. Special lighting is provided by lenses and mirrors which make it possible to direct light in such a manner that no shadows are cast where the operation is being performed.

It is planned to add, as soon as possible, a neuro-surgery unit. This unit will include an operating room suite, separated from the general operating room. In it will be installed the most modern equipment required for investigation, diagnosis and treatment. Adjoining the suite will be two wards of six beds each, with six private rooms on the same floor.

Special Features

The marble-walled rotunda, indirectly lighted from a false dome in the ceiling, has a terrazzo floor. The main passenger elevators ascend from this rotunda. One of the



Upper left: There are 80 private rooms on three floors, each with its own toilet and nine with baths. All rooms are wired for telephone and radio.

Upper right: The auditorium for clinical conferences and student lectures has a good stage, is fully equipped, and has a motion picture projection booth.

Middle: General wards for ten and twelve patients are screened by curtains and wired for radio reception. Each patient has his own writing and make-up table, reading lamp, and individual clothes locker. Note glassed-in "quiet room" at rear for very ill patients needing isolation. All rooms are tastefully decorated.

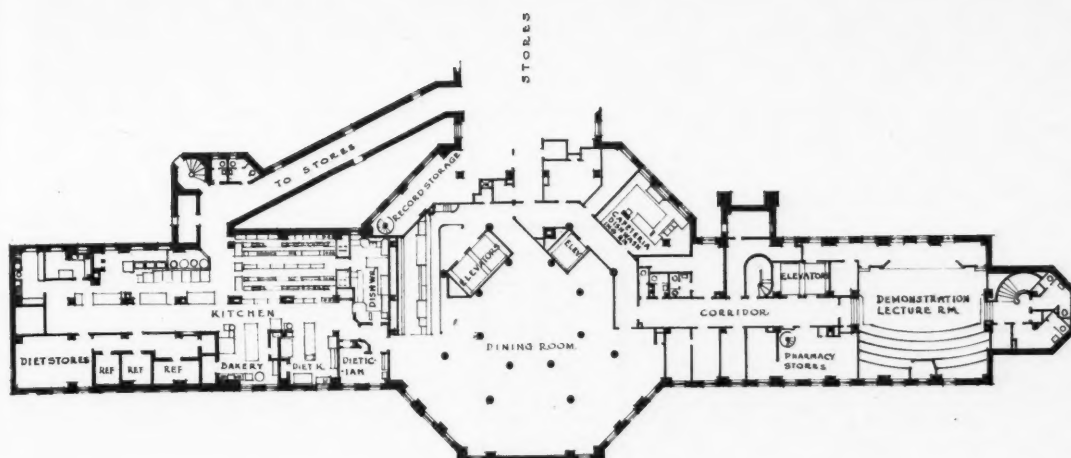
Lower: The tray conveyor food service carries trays from assembly table to vertical lift going to all floors.

thirty-six clocks installed throughout the building is set opposite the entrance. These time-pieces, together with the five special operating room clocks, are linked with a master clock which regulates them automatically.

From the central supply system situated on the twelfth floor, runs a system of pneumatic tubes carrying supplies to all parts of the hospital. Records of orders can also be sent to different sections through this medium. In addition, two dumb waiters operate to the third floor.

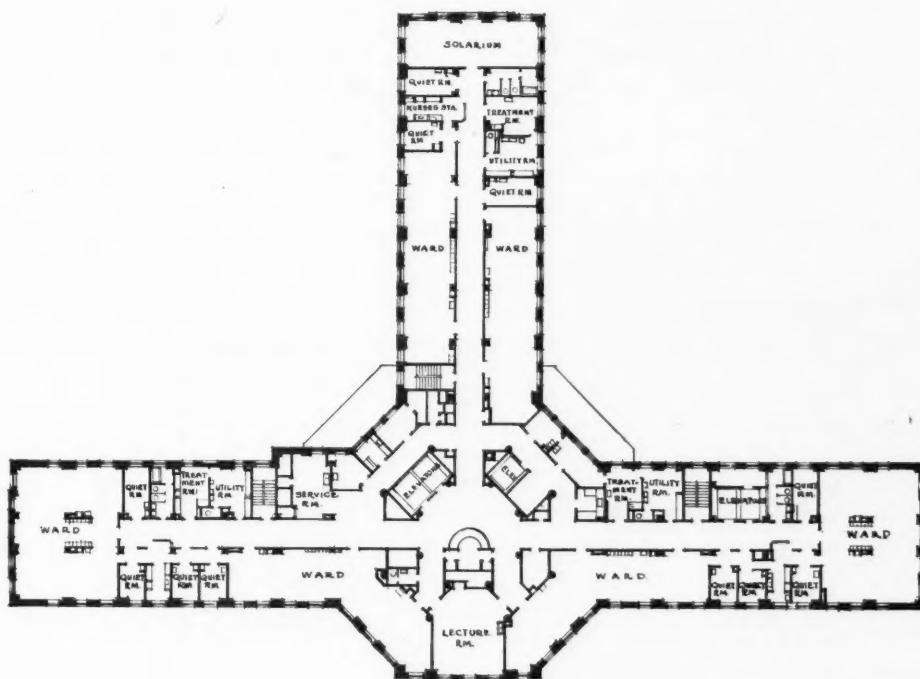
The intercommunication system is noteworthy in that signal lights are used when calling any doctor or official, who may then communicate by inter-office telephone with the central office.

Since the hospital is T-shaped, and the desk of the floor supervisor



PLAN OF FIRST FLOOR

GRAPHIC SCALE
0 5 10 15 20 25 30



PLAN OF 4TH 5TH & 6TH FLOOR

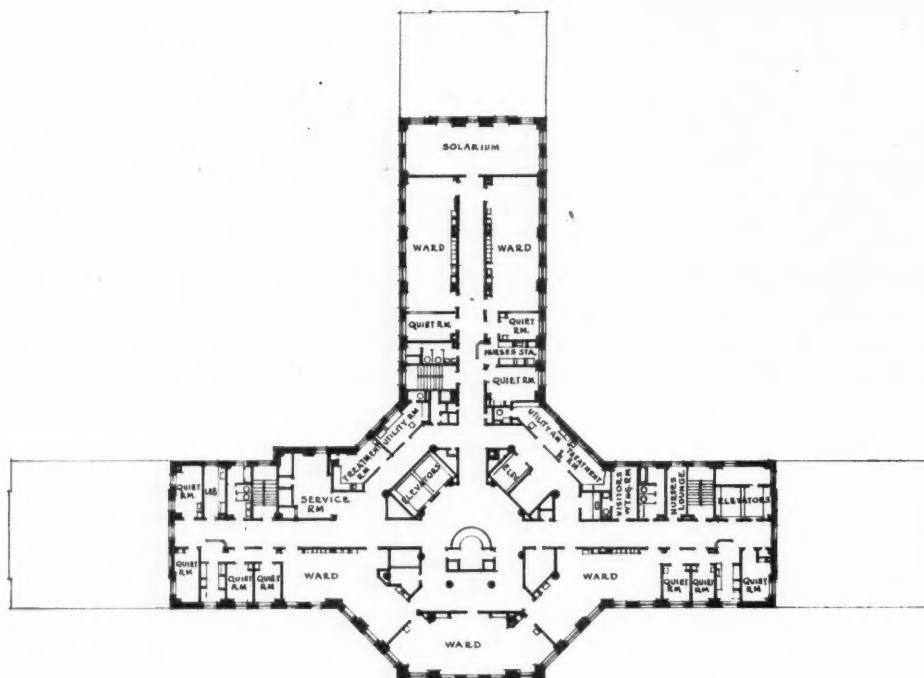
forms a half circle at the junction of the "T" facing down the west corridor, efficient supervision is possible at all times. From this station there is an unobstructed view along these sections to the remotest end of the corridors.

All buildings are linked by an underground tunnel system, some

800 feet in all of concrete tunnels extending from the main building to the old hospital, nurses' residence, pavilion, boilerhouse and laundry. The pathological building is also connected by a tunnel. This system facilitates transportation of patients, equipment or stores.

The out-patient department, oc-

cupying most of two wings on the third floor, will provide expanded service to the general public. Primarily designed for the diagnosis and treatment of ambulatory patients who need follow-up care, it will also afford treatment to those patients needing hospital attention, but whose condition does not necessitate hospi-



PLAN OF 7TH & 8TH FLOORS

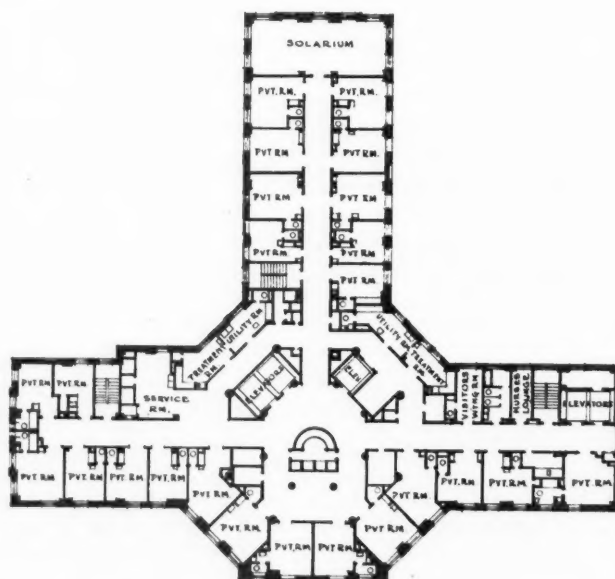
talization. Arrangements are being made for the conducting of a number of departments, each dealing with a different branch of medicine and diagnosis.

The auditorium on the ground floor, with plastic-covered stainless steel chairs on circling concrete levels, has a seating capacity of 275. It will also be used as a teaching and clinic room.

Since it is the desire of the authorities that the new hospital will be of the greatest possible benefit to the province, it will serve as a training centre for the medical profession, for nurses and technicians. Personnel from other hospitals wishing to take refresher courses will have an opportunity to do so, and training of students in dietetics will be carried on as soon as living quarters become available. The teaching equipment provided is of the finest type procurable.

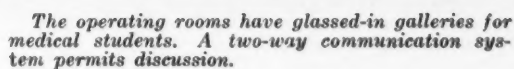
Construction

The building is constructed of reinforced concrete, beam and girder design. Two heavy steel girders



PLAN OF 9TH, 10TH & 11TH FLOORS

"The modern hospital is now an essential element in the program of public welfare and the life of the community. . . . A community with good and ample hospital services is a better and a safer place in which to live." This statement was made by Dr. C. M. Bethune, superintendent of the hospital, and the citizens of Nova Scotia may well be proud of this most recent effort to provide for them.



Basic Considerations in a

HUMAN RELATIONS PROGRAM

IN recent years, there has been increasing interest in the problems which concern the people within an organization. The book shelves bulge with publications; journals and periodicals carry frequent articles. Much of this literature, however, is concerned with what might be called the "tools" or "techniques" of personnel administration—selection methods, job evaluation, incentive schemes, promotion policies, and so on. These things are important, but they do not appear to be enough. In too many cases, the most elaborate personnel programs have yielded disappointing results. Something else is needed. What is it?

In our industrialized society, there is a tendency to think in terms of technological and economic logics. Very often the assumption is made that industrial (and hospital) organization is a technical problem; also, many policies are introduced and decisions made on the over-simplified assumption that man is a rational economic animal. The increasing break-down of co-operative activity evident in strikes, turn-over, absenteeism and restriction of output, forces one to question these assumptions upon which action has been based.

If traditional ways of looking at an organization have often proved misleading, perhaps what might be called a "human relations point of view" should be added.

In the area of human relations it

Condensed from an address, London Institute for Hospital Administrators, April.

Mr. Trimble is Fellow in the Canadian Institute of Industrial Relations, and Fellow, Department of Hospital Administration, University of Toronto.

**William Trimble, M.A.,
University of Toronto.**

is dangerous to speak in broad generalities. However, there are certain concepts which may be useful for those who must understand and deal with people at work. Before outlining what some of these human relations concepts are, one would like to point out that it is not our intention to tell anyone how to deal with people. No formula is being prescribed. Furthermore, as most, if not all, of what is here said is common knowledge, our attempt will be only to systematize what is often understood intuitively.

The Hospital is a Social System

A hospital can be considered as a *social system*—a little society made up of people who are in various ways associated with each other. The people who work in the hospital do not constitute just a rabble of individuals, each one pursuing his allotted task in isolation, but each person has a fairly definite place in the social structure and has fairly well established relationships with other people. The work and general behaviour of any one person or group of people may have far reaching effects on many others. Like the cells in a living organism, the people group together to form different parts, each having characteristic functions and activities. You cannot hire, transfer, demote, fire or reprimand any one person without considering the effects on the whole group.

The social structure may be thought of as existing in a state of equilibrium, in that any change which disrupts the accustomed re-

lationships between people is strenuously resisted. How is the structure held together? How is it that people are related to each other? In what ways are the various pieces related to the whole?

The Hospital is Permeated With Status Relationships

A very important relationship in any organization is that between an individual and his direct superior. At the top of the organizational hierarchy sits the "big boss"—the man who has no superior and, beneath him, layer after layer of less important bosses down to the worker who is in the unfortunate position of having no one whom he can tell what to do.

Often policies can be introduced thoughtlessly in the superior-subordinate relationship which will pull the various layers apart and increase people's concern over their relationships with superiors. Nearly everyone appears to focus his attention upward to the person who allocates the work, who gives rewards, or who passes on a good word to the higher-ups. The likes or dislikes of the boss, his interests, his casual comments, the clothes he wears—all of these are of interest to the subordinate. He wonders, too, whether he is over-friendly with those under him or too aloof, whether he talks too much or not enough. He spends much time in trying to understand the expectations of his superior and in wondering if he fulfils these expectations.

The problem of relative status and of where each person fits into the system permeates every corner of an organization, and can be most puzzling and annoying to the administrator who does not understand it. Some of the more famil-

iar status distinctions are those between shop and office, between hourly rated and salaried workers, between old timers and new comers. In this status system, people are related to each other by means of what we might call "status symbols". Their importance is evident in the armed forces where pips, braid and ribbons display one's position for all to see. Likewise in the hospital, uniform plays a part. There are undoubtedly many more status symbols which, while less obvious, are none the less very important to the people concerned. We might mention, for example, the size of a person's desk, the number of telephones on it, and whether the desk is next to that of the big boss or on another floor. Among manual workers it may be accepted that only the foreman wears a tie, that the machine operator and not his helper uses the big wrench to set up the machine, and so on.

The relationships between people, and the ways in which people feel about each other, are closely related to these symbols. To some extent they determine who initiates action for whom, who says what and to whom, and how people feel in each other's presence. The worker whose overalls and greasy hands betray his position will probably feel somewhat inhibited when standing before a large mahogany desk in an office carpeted with broadloom. Perhaps here is a partial explanation of why the "open door policy" seldom produces any callers from the lower levels.

Executives often deny that there are such things as informal status relationships in their organization, or say that they are foolish, or indicate the pettiness of those concerned. However, these do exist and there is no known way of stopping people from trying to "size up" one another, or to keep them from being concerned about their own status.

The Hospital Organization as a Communication System

We may also consider any organization as a communication system, with information passing up, down and sideways, along various written and oral channels.



Honour Roll Unveiled at Sudbury

As a special feature of the observance of National Hospital Day, St. Joseph's Hospital, Sudbury, conducted an impressive ceremony in the unveiling of two framed rolls of honour, tributes to the doctors and nurses of the hospital who had served in the armed forces during the First and Second Great Wars. Shown above from left to right are: Miss Lois Riddell, student nurse, who paid tribute to the nurses with war records; Dr. McInnes, who unveiled the doctors' scroll; Miss Patricia Fitzgerald, student nurse, who unveiled the nurses' roll of honour; and Sr. St. Flavie Domitille, Superior.

The most familiar channel of communication, of course, is that which follows the line of authority. This chain of command provides the series of relationships through which the decisions of the big boss are carried down through the organization. Also, information flows back up the line to the top.

This means of communication, however, is not always as clear cut as it is often thought to be. A pencil line on an organization chart does not necessarily mean a clear line of communication. Because of the anxieties involved in the superior-subordinate relationship, this channel has a number of peculiarities which affect the quality, quantity and speed, of transmission. There can be so many distortions in this channel, that it is often difficult for a person to have any clear picture of what is happening a couple of layers below him.

What is likely to happen to information as it passes up the line

to the superior? How difficult is it for the administrator to keep his finger firmly on the pulse of the organization? Information which will please a superior tends to reach him more quickly than bad news, which is often held back or distorted. People just do not like to go to a superior with news of failures, unless, of course, there is a danger that someone else will pass on the story first. Such news is often more or less filtered, coloured, surrounded by excuses, and delayed in its presentation. It sometimes happens, for example, that a senior executive will speak of his "one big happy family", at the very time that trouble is brewing at the lower levels. If a superior is not receptive to information, or if he is too receptive, he just does not get it. For instance, I once heard an executive say this about his superior. "I used to go in and see him just to talk things

(Continued on page 88)



L'Hôpital Saint François d'Assise

A l'angle de la première avenue et de l'avenue Leclerc, dans le quartier Limoilou à Québec, s'élève majestueux l'Hôpital Saint-François d'Assise. La nouvelle aile, commencée à l'automne 1944, a reçu sa bénédiction le 14 décembre 1947. Le plan en fut conçu par les architectes Caron et Blatter, l'entreprise fut confiée à M. Frenette.

L'édifice rectangulaire de 10 étages de hauteur couvre une surface de 254 x 50 pieds. L'extérieur de la construction est en pierre de taille. Vu de la 1ère avenue, l'hôpital offre au spectateur l'aspect d'un immense navire qui semble s'avancer lentement, magnifiquement. Vu de face, avec son entrée principale toute de verre, il est attirant et on ne peut résister au désir de pénétrer dans son enceinte. Deux entrées latérales donnent directement sur les escaliers qui conduisent dans les différents étages.

Le portique est de granit; le vestibul de vitrolite, d'acier inoxydable, de travertine et de terrazo. L'éclairage est indirect. Au premier étage à gauche, le bureau d'admission, le département de physiothérapie avec tout l'outillage des plus perfectionnés. A droite, le tableau des échanges téléphoniques qui contrôle 148 lo-

**Sister Ste. Gertrude,
Supérieure,
Hôpital Civique,
Quebec, P.Q.**

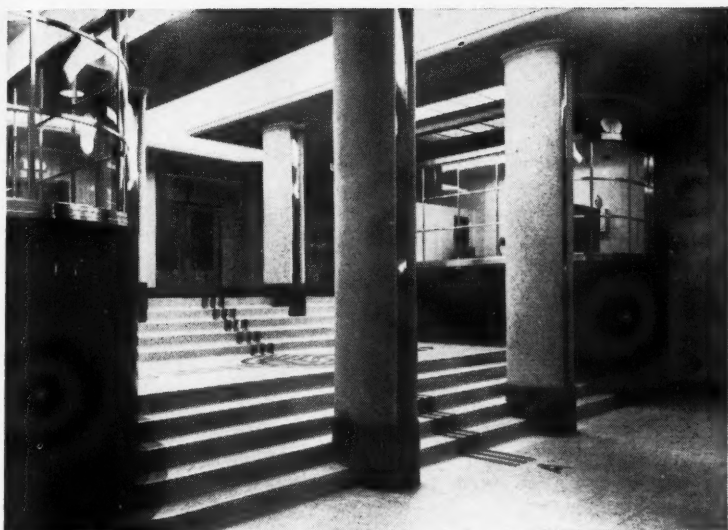
caux, le système d'appel général, le tableau lumineux des médecins, l'information. A droite également, le vestiaire des médecins, le bureau du président, la bibliothèque, la salle de conférence, les chambres des internes, et cetera.

Le deuxième étage est affecté uniquement à la pharmacie et au bloc opératoire qui comprend 9 salles d'opération, une salle post-opératoire, deux salles d'anesthésie, une salle d'approvisionnement central, une salle de travail, deux vestiaires dont l'un pour les médecins et l'autre pour les infirmières laïques, un buffet et enfin un bureau pour la directrice des salles d'opération. Voici pour ce qui concerne chaque salle proprement dite: air climatisé, lampe germicide, négatoscope, succion hydraulique, cabinet d'instrument intra-mural en acier inoxydable, commutateur et prise de courant au mercure, cadran électrique, système lumineux pour indiquer que la salle est occupée, stérilisateur d'eau et d'instrument entre les salles. Les murs sont en vitrolite couleur pastel.

Les 3e, 4e, 5e, 6e, 7e, étages sont

destinés aux services des malades: médecine, chirurgie, obstétrique, gynécologie, urologie, orthopédie, dermatologie, et cetera. Tous les départements sont uniformes: au centre, poste des gardes-malades pourvu de toutes les commodités; en face, cuisinette des services, spacieuse, éclairée, ensoleillée. L'outillage est conforme aux exigences modernes: armoires chauffantes, table à la vapeur, laveuse de vaisselle électrique, urnes à thé et à café, frigidaire, poêle électrique, et cetera. Quant aux chambres, disposées latéralement, elles sont meublées de façon à procurer aux malades tout le confort possible: toilette attenante, placard individuel pour les chambres à trois lits; salle de bain, électro-voix et appareil téléphonique pour les chambres privées. L'appel d'urgence est organisé même dans les chambres de toilette. L'éclairage de nuit spécial est utilisé dans tous les services. Enfin, les salles de traitements, d'utilité, les armoires chauffantes concourent à rendre le service plus facile. Deux chambres d'isolement favorisent la réclusion des grands malades et leur surveillance. Le solarium à l'extrémité sud permet également la détente, le repos des convalescents.

Le 8e, étage plutôt de luxe, ne



Hall d'entrée

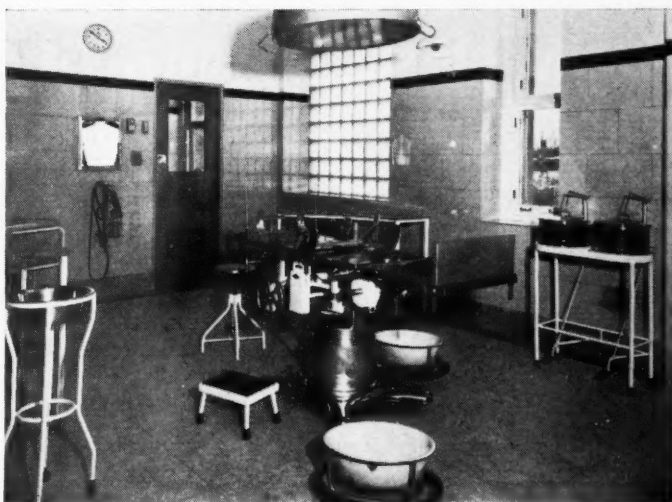
comprend que des chambres privées avec salon. Deux terrasses aux extrémités procurent délassément aux malades tout en leur donnant une vue magnifique sur la ville et ses horizons.

Et de là, nous descendons au rez-de-chaussée où se trouvent d'un côté le laboratoire, le dispensaire avec ses différentes salles d'attente, de consultation, de traitement, de repos. Une salle d'accidentés est même aménagée près de l'entrée des ambulances. De l'autre côté, les cafétérias, la cuisine générale avec son installation des plus pratiques et des plus modernes. Ses divisions, ses subdivisions multiples permettent rapidité dans le travail et maximum de rendement. Au centre les immenses bouilloires, les poeles AGA, électrique et à gaz, les dressoirs en acier inoxydable, les appareils divers, les machines de toutes sortes. Ici, la cuisine des diètes et des régimes si pratique, si nécessaire. Là, un petit coin tout ensoleillé affecté à la préparation des légumes. A gauche, la préparation des viandes avec toute l'installation requise. A droite, la fabrication exclusive des desserts et de la pâtisserie avec un immense fourneau et l'outillage nécessaire. C'est jusqu'à l'armoire à pain aérée, genre tourniquet qui conserve frais et bon le pain en si grande quantité. C'est encore en plus du système de réfrigération ordinaire, cette série de 24 petits frigidaires superposés qui facilitent tant le bon service avec ordre et économie. Et enfin, l'air conditionné, l'éclairage fluorescent,

la hotte aspiratrice (fumivore), favorisent les conditions de travail.

Au sous-sol: salon mortuaire et dépendance, salle d'autopsie, d'embaumement avec frigidaire; magasins de réserves générales, vastes frigidaires de légumes, de viandes, de conserves, et cetera, avec température appropriée; chambres des tableaux de distribution électrique, de transformateurs; salle de stérilisation des matelas; système vacuum, incinérateur, chute à linge. Enfin un sous-terrain conduit à la chaufferie où deux imposantes bouilloires à l'huile d'une force de 200 chevaux vapeur desservent à la fois l'ancienne et la nouvelle construction; deux réservoirs à l'huile d'une capacité de 3714 gallons alimentent ces bouilloires. De

(suite en page 84)



Salle d'opération



Chambre de malade



Group of Registrants at the Institute

Institute for Sisters Held by Montreal Conference

AN Institute, sponsored by the Montreal Conference of the Catholic Hospital Association with the assistance of the University of Montreal, and the American College of Hospital Administrators, was held in Montreal May 9th to May 23rd, inclusive.

The number of students attending the Institute was, due to lack of accommodation, limited to seventy-five, but invitations were sent out to all hospitals for special lectures and at times as many as two hundred and fifty persons participated in the discussions. Hôpital du Sacré-Cœur, directed by the Sisters of Providence, provided accommodation for the hospital sisters attending the courses. Reverend Mother Audet, F.A.C.H.A., greeted the assembly on behalf of the College.

In order to enable the students to witness various demonstrations, tours were organized to a number of hospitals in the city. Of special interest were the lectures delivered by Dr. Malcolm T. MacEachern, Associate Director of the American College of Surgeons, on the point rating system for the evaluation of hospitals. Dr. MacEachern also conducted open forums, dealing with medical staff organization, the duties of the medical director in the hospital, and suggestions for the improvement of me-

dical records. Many doctors from hospitals conducted by Religious and non-religious attended these sessions.

Much attention was centred on the discussion periods, legal problems and the functions of the medical director proving of particular interest. After eight days of intensive work, lectures were suspended and all students enjoyed a day of relaxation in the country.

In order that students might qualify for the certificate which was issued at the end of the course, each one was required to write and deliver a ten-minute paper on one of the subjects included in the curriculum.

At the close of the Institute a vote of thanks was expressed to all those who participated in making the course a success. Sincere gratitude was expressed to the Sisters of Providence at Hôpital du Sacré-Cœur for their gracious hospitality which enabled the student Sisters to take advantage of the many features of the Institute. Special tribute was paid to Reverend Hector L. Bertrand, S.J., President of the Catholic Hospital Council of Canada, who directed a great deal of the preparatory work, and to Mr. M. R. Kneifl, executive secretary of the Catholic Hospital Association of the United States and Canada, whose valuable

suggestions and advice were greatly appreciated.

A similar Institute will be held in Quebec City from 8th to 23rd August, under the auspices of the Quebec Conference, with the assistance of the University of Laval and the American College of Hospital Administrators.

A.H.A. Appointments

Charles T. Dolezal, M.D., superintendent of City Hospital, Cleveland, has been appointed assistant director and secretary of the Council on Professional Practice, filling the position left vacant with the resignation of Hugo V. Hullerman, M.D.

Dr. Dallas G. Sutton, M.D., Rear Admiral (MC) USN (Ret.), director of study, Government Hospital Relations at the Washington Service Bureau, has been appointed secretary of the Council on International Relations. Mr. C. J. Foley, secretary of the Council on Public Relations, will, in addition, become secretary of the Council on Association Relations following the resignation of Mr. William G. Simmons. Miss Helen V. Pruitt, librarian of the Bacon Library, has been appointed also secretary of the Council on Education of the American Hospital Association.

Services Rendered by the Admitting Office

TO the admitting office the arrival of a patient means the completing of the necessary documentation and business record and turning him over to the care of the professional staff. The first duty of the office is to maintain an adequate record of the bed complement of the hospital, both occupied and available. This must contain up-to-date data on the identity and location of all patients in the hospital, the names of those expected to leave and, as far as possible, the names of those expected to arrive. The doctor making arrangements for the admission of a patient will contact the admitting office and it must be able to tell him what accommodation will be available and when it can be obtained. Always being able to give the doctor a quick, frank, and accurate picture of the situation will build up his confidence in the office and make the relationship between the office and the medical staff one of mutual respect and co-operation.

When the Patient Arrives

The admitting office should be so located as to be the obvious place for the incoming patient to go, and he should be met and greeted by the admitting officer. A great deal of careful thought has been given, and a good deal of splendid material written, about the psychology of receiving patients into the hospital; also, about the qualifications and personality desirable in admitting officers. This subject is a study in itself and it is not our purpose to go into it fully. A simple comparison will suffice to illustrate this phase of admitting.

Think of the best hotel clerk you ever saw. When you walked in the

Murray Ross,
Secretary-Treasurer,
Royal Alexandra Hospital,
Edmonton, Alberta.

door, his desk or counter was in plain sight and you automatically went over there. When you told him your name he acted as though he expected you. He was courteous and, at the same time, business-like. He was able to answer your questions and put you at ease. He had you fill in a registration card and told you what room you were going to, and he either took you himself or had you and your baggage taken there. As you went to your room and thought back over your entrance into the hotel, you felt you had been well served. You liked your reception and the man who received you. You are well on your way to liking everything about the hotel.

After the patient has arrived, he is taken into a private office for interview and documentation. There is a good deal of information which must be recorded. It is suggested that first, in order to obtain this information with the least annoyance to the patient, any unnecessary questions on the admittance form be eliminated, and, secondly, that they be arranged in natural sequence so as to give the questioning a conversational tone rather than one of straight interrogation.

The information to be obtained consists of a combination of statistical and financial data. It must be taken and recorded accurately and carefully. Bear in mind that the questioning is a two-way affair. The patient as well as the hospital requires information, and the admitting office must be a virtual encyclopaedia, fully informed on hospital rates, rules, regulations, et cetera.

Financial Aspects

The financial information which must be recorded deals with the method by which the patient's hospital account will be paid, and it is suggested that this matter of granting credit to a patient is a very important one to most hospitals. The control of credit in a hospital is much more complex than in a commercial organization inasmuch as the hospital renders service to a complete cross section of the population regardless of position in the social scale, credit standing, financial ability or reputation. In a hospital it is not so much a matter of whether or not to grant credit, because the possibility of refusal is almost always eliminated on humanitarian grounds. It is more the manner in which it is granted, the accuracy of all information taken and the completeness of the understanding reached with the party responsible for payment. The manner of admission of a patient is a very important part of the collection picture.

When a patient is admitted to hospital, his care immediately starts costing anywhere from five to ten dollars per day; in effect, every day the admitting office is handing out ten dollar bills to every conceivable type of risk. This need not be a deplorable situation as long as it is remembered that there are different ways of doing it. The person responsible for the documentation of incoming patients should be thoroughly familiar with the hospital's credit policies and fully trained in the art of extending credit and making arrangements for repayment.

In recent years, the number of plans for prepayment of hospitalization, through non-profit plans, private concerns and government-sponsored agencies, have greatly increased. It is desirable, in fact almost essential, that the admitting office be familiar with benefits which are payable under such plans and the limitations that exist in them, and it must also be sure that the patient or responsible party is aware of both the benefits and the limitations.

Above all, the understanding as to how the hospital account is going to be taken care of, or not taken care of, as the case may be, must be thorough and complete as between the patient or responsible party on one

Presented at the Western Institute for Hospital Administrators, Edmonton, 1947.

hand, and the admitting office on the other. This must be recorded on the admission form in plain, straight-forward language, so that it cannot be misinterpreted.

Before leaving the financial phase of the duties of an admitting office, let us suggest some of the things which might be regarded as basic requirements in securing good results.

1. A general guiding policy must be laid down by the owners and directors of the hospital, through the administrator.

2. Personnel must be selected who are already trained or can be trained in this aspect of the work and who possess the qualities of intelligence and personality to meet all the other requirements of their position.

3. Training and instruction must be provided by a person or persons on the hospital staff possessing the necessary knowledge concerning these matters, and these same people must thereafter pursue a course of constant checking and supervision of the work being done, maintaining constant vigilance to see that the admitting office is kept up to date on all pertinent developments and government regulations, provisions of in-

surance or hospitalization plans or contracts, hospital rates and all similar matters.

The method adopted to fulfil these requirements will vary considerably according to the type and size of the institution. In a small hospital, the matron or sister in charge must keep herself fully informed by study, reading of hospital journals and other sources of information, attending conventions, and discussing problems with other hospitals whenever possible. In the small or medium sized hospital employing a full-time secretary, his will be the task of keeping first of all himself and, secondly, the other members of the staff thoroughly informed. In the larger hospitals where the problem is more complex because of a larger staff and more intricate organization, there will likely be a credit manager who will be the logical person to guide and control the admitting office. In fact, one might say that if he does not do so or, at least, have a very considerable amount of control and supervision over it, he will have one strike called on him before he steps up to bat in an attempt to operate his department effectively and efficiently.

"An account well opened is half

collected"—we have all repeatedly heard such expressions or slogans and possibly the most important single feature in the whole hospital credit and collection picture is what happens at the time of admission. It follows naturally that the person or persons whom your board or administrator hold responsible for credit and collection results must direct the activities of those extending the credit.

Admitting Records

After the documentation of the patient has been completed, the admitting office must see that the patient is handed over to the ward to which he has been assigned, or to the admitting ward where one is provided. It is necessary to take or send to the ward, along with the patient, a card or form showing the name of the patient and other pertinent statistical data. After all information has been obtained and the patient taken care of, there still remains a lot for the admitting office to do in the way of completing records. This may consist of opening up a ledger sheet, recording the admission in the register, notifying the information desk, telephone operator, dietary department, et cetera.

All admitting records should be typewritten for speed, clarity, and accuracy, and printed forms worked out which will cut down multiplicity of operations and costly repetition in recording the data required in all the necessary places. Full use should be made of multiple carbon forms or duplicating devices and the whole procedure streamlined so as to result in all the various forms being completed, insofar as possible, in one operation.

Other Duties of the Admitting Office

Hospitals must comply with the requirements of the law which vary in different provinces in respect to proper registration of newborn infants and deaths which occur in hospitals. The admitting office, being in close contact with the wards and the happenings in the institution, is in an ideal position to handle this branch of the work, if other factors allow.

All hospitals are required to keep a fairly extensive amount of statistical data, both for effective internal administration and for the purpose of

(Continued on page 94)



Helicopter Ambulance

In order to expand the effective range of its hospital emergency facilities, the new Herrick Memorial Hospital in Berkeley, California, has a specially constructed roof for the landing of a helicopter ambulance. Elevators run from the heliport to the operating rooms thus making it possible for emergency patients to be wheeled there directly. Persons injured at great distances can now be flown quickly to the hospital.

Before — and After

The Metamorphosis of Four Houses into a Nurses' Residence

A PROBLEM confronting the Herbert Reddy Memorial Hospital, Montreal, for some time, was the lack of an adequate nurses' residence. Quarters for graduates and students alike occupied three floors of the west wing of the hospital and the overflow lived in three houses. Formerly these had been private residences, but were now owned by the hospital and separated from it by a twelve-foot lane.

Obviously this arrangement was extremely unsatisfactory. As a result of the rapid changes in the general nursing situation during the past few years, combined with the crying need in our own case for an extension to the auxiliary service departments, the problem became pressing; a nurses' residence had to be acquired as quickly and as economically as possible.

The amount of money at our disposal was limited and the Board did not feel the time ripe for an appeal to the public. It was finally decided to purchase another house adjoining those we already owned, making a total of four. These were then to be converted into one and joined to the hospital by a two-storey structure. A small extension of the same height, but built so that four more stories could be added, was also included in the plans. The sub-grade or basement floor of this extension was to form part of a larger dining room for the nursing staff and the ground floor was to be part of the x-ray department.

This plan presented a number of rather interesting problems. Although the ground floor level of both the hospital building and the houses was the same, there was a difference of twenty inches between the basements. The floor level of the practice nursing room accordingly was lowered,

H. C. Allnutt,
Superintendent,
Herbert Reddy Memorial Hospital,
Montreal.

together with a few feet of that of the basement corridor, the difference in the latter being taken care of by two steps. Subsequent experience has taught us that a ramp would have been better and this will replace the steps as soon as possible.

Without cutting up the rooms too much and without undue loss of space we were able to run a straight corridor (5'9" in width) through the entire length of the four houses on the ground floor. Largely due to cost, it was considered impracticable to do the same with the first floor or the basement.

This corridor permits proper sup-

ervision with a minimum staff since the receptionist's desk is strategically located at one end, controlling the entrance as well as the stairways from the first floor and basement.

As the houses were substantially built, most of the original woodwork was used and the home-like character of those floors assigned to living quarters was carefully preserved. Only in the basement, which was allotted to the training school, was any attempt at modernization made. Fluorescent lighting and an air-conditioning unit were installed, and a coloured asphalt floor laid.

Three of the old doorways were replaced by windows and the entrance halls turned into single bedrooms measuring 18' x 6'6". The original entrance to the fourth house, therefore, became the only entrance to the nurses' residence from the street. It might be noted here that as a result of this change the buildings present the appearance of a single unit from the outside.

All the bedrooms were fitted with basins and washable wallpaper was used instead of paint. As an added protection, the paper around the basins was covered with transparent varnish.

The entrance hall was also papered, but the corridor and stairway walls were painted, as well as all rooms in the basement. The ground floor of the two-storey structure



Above photograph shows entrance to residence and method of joining to the hospital.—Photographs, courtesy Associated Screen News.



A corner of the sitting room



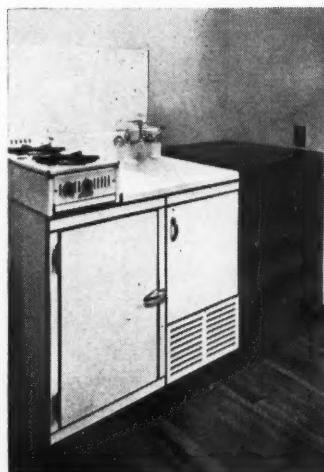
A bedroom

joining the houses to the hospital building was made into a sitting room, 19' x 12', the rest of the space being taken up by the corridor, which at this point widens to 8'8". The basement portion was assigned to the hospital stores department, giving it an additional 300 square feet of badly needed storage space.

Since the structure is not fireproof, there are two exits on the first and ground floors and three in the basement, with four fire doors on each floor. By using two convertors, it is heated with hot water from the hospital plant.

The finished building has given us living quarters for forty-three nurses, or more if bunks are used; three sitting rooms and a recreation room; two kitchens and a kitchenette; a students' library, class room and science and practice nursing rooms; a laundry and a sewing room.

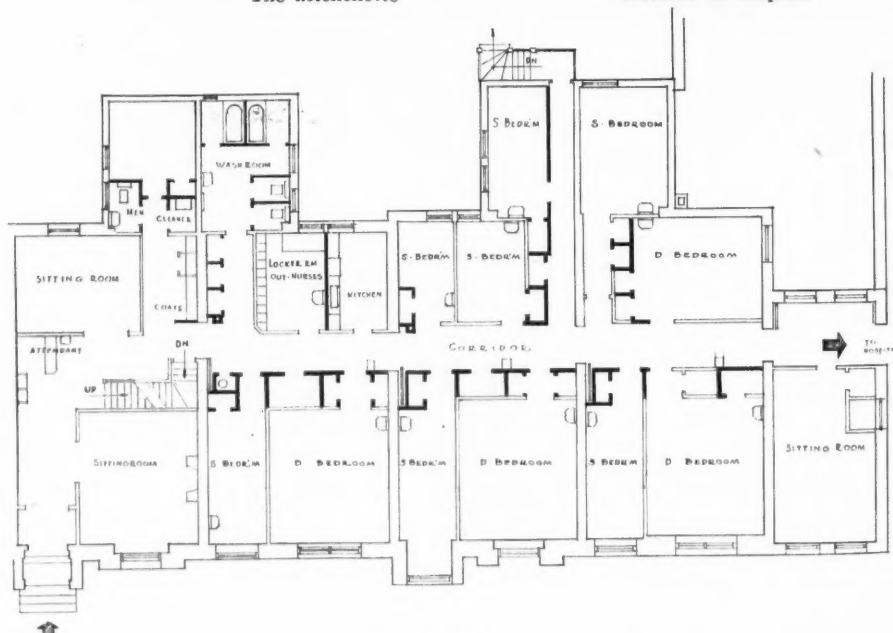
The credit for the planning should go, not only to the architect, Mr. A. Leslie Perry, B.Arch., M.R.A.I.C., P.Q.A.A., but also to the then superintendent of nurses, Miss D. I. MacRae, R.R.C., Reg.N., who has since retired from the nursing profession.



The kitchenette



Corridor to hospital



Ground Floor

Maritime Meeting

Held at St. Andrews

6th Annual Convention M.H.A.

APPROXIMATELY 300 enthusiastic delegates and guests registered at the Algonquin Hotel in St. Andrews-by-the-Sea, N.B., for the sixth annual meeting of the Maritime Hospital Association, June 15 to 17.

Among the guests who contributed to the program were: Mr. A. V. Whitehall, Secretary, Council on Government Relations, and Director, Washington Service Bureau, American Hospital Association; Dr. A. L. C. Gilday, Treasurer, Canadian Hospital Council; Dr. G. Harvey Agnew, Executive Secretary, Canadian Hospital Council; Rev. Hector L. Bertrand, President, Catholic Hospital Association; Hon. A. W. Matheson, Minister of Health and Welfare, P.E.I.; Dr. J. A. Melansen, Chief Medical Officer and Registrar General, Department of Health and Social Services, N.B.; Major C. M. Young, Office of the Fire Marshal, Fredericton, N.B.; Mr. A. Hammond, Manager, Corner Brook General Hospital, Corner Brook, Newfoundland.

The general convention was preceded on June 14th by meetings of the Maritime Conference, C.H.A., and the Maritime Hospital Aids Association, which are noted elsewhere in this issue. Sectional meetings of the M.H.A. were held on Tuesday, June 15, and the following morning.

In his presidential address on Wednesday afternoon, Dr. J. A. Clark reviewed progress made in the adjustment of rates between general hospitals and the Department of Veterans Affairs and Workmen's Compensation Boards in Nova Scotia and New Brunswick. He urged that the committee working on both aspects continue their efforts until they arrive at rates satisfactory to all concerned. Because of rapidly increasing costs, larger hospitals, in particu-

lar, are suffering considerable loss under present arrangements with these two bodies.

Visit to St. Stephens

'Mid glorious sunshine which glistened on the waters of Fundy, delegates drove to St. Stephens where they visited Chipman Memorial Hospital. This 78-bed institution overlooks a lovely inlet of the sea. The large wards have windows on three sides as well as wide verandas so that patients' beds can be wheeled outside on warm days. Having viewed the hospital under the guidance of the superintendent, Miss R. E. Follis, delegates were entertained at tea in the nurses' home by members of the local hospital aid.

Blue Cross

Lively discussion marked the session presided over by Dr. J. A. McMillan, President of the M.H.S.A. On behalf of the Blue Cross plan he brought to the attention of delegates two specific points:

1. In view of the fact that the plan is now a large organization (it covers 29 per cent of the total population of the three provinces), it is not practicable to change the rate of payment to individual hospitals whenever such hospitals find it necessary to raise their charges to the public. He assured association members that the Plan would continue to pay the current rates but requested due notice prior to any change.

2. A proposed revision of the service contract between the Blue Cross Plan and member hospitals by which hospitals would guarantee services to patients for whatever period their fees were paid, even should circumstances arise under which the Plan could not pay the bills. In other words, the hospitals were asked to underwrite the Plan and back it with

a service guarantee, for the protection of all individuals enrolled.

Since the Blue Cross Plan is financially sound and since its economic welfare is bound up with that of the hospitals under the sponsorship of which it originated, both of these proposals were found acceptable by members of the hospital association.

Public Relations

Mr. Donald Henshaw of the MacLaren Advertising Agency, Toronto, gave a stimulating address on "The Value of a Well-Planned Public Relations Program for Our Hospitals". He defined public relations as essentially human relations and suggested that any such program must be stemmed locally; i.e., begin at home, and be designed in accordance with local conditions. Mr. Henshaw outlined the program of public relations which the Canadian Hospital Council would like to see developed in co-operation with the various associations.

Trustee Session

Three splendid addresses on various phases of the relationship between the hospital and its trustees were heard, the speakers being: Rev. Mother Ignatius, Antigonish; Dr. C. M. Bethune, Halifax and Dr. D. F. W. Porter, Director of Hospital Services for New Brunswick. Dr. C. J. W. Beckwith of Halifax discussed "What the Community Expects from the Hospital in Disease Prevention". These addresses will be published in subsequent issues of the journal for the edification of our readers.

There followed an open forum under the able and alert direction of Dr. Harvey Agnew. Trustees, administrators, and visitors all joined in enthusiastic and highly profitable discussion of problems relating to the organization, administration and control of hospitals.

Shortage of Nurses

The nurses' session under the chairmanship of Miss Rhoda MacDonald, was largely given over to consideration of ways and means of relieving the prevalent shortage. Sister Catherine Gerard of Halifax gave a brief address in which she urged the immediate need for a nation-wide survey to ascertain the ac-

tual shortage, the conditions under which nurses work, and to gauge educational facilities across the country. Dr. Harvey Agnew emphasized two points: (1) the committee undertaking such a survey must represent the public at large, not just the nursing profession and the hospitals; (2) the need for haste. He also expressed the hope that certain funds for the study may be obtained from the Dominion government through its recent health proposals.

Further Interesting Addresses

At the annual dinner on Thursday evening, the guest speaker was Mr. Albert V. Whitehall of the American Hospital Association. In a thought-provoking address on "Hospitals and Government", Mr. Whitehall traced the modern tendency to depend upon governmental agencies for more and more of our social services, but stressed the belief that in the matter of providing hospital care "we are perhaps better qualified than any other group to give leadership and direction". After dinner, delegates were entertained at the Casino by the exhibitors—the program including hilarious impromptu skits, a movie and a sing-song.

The final convention session on Friday included an instructive address by Major C. M. Young of Fredericton on "Fire Prevention",

and a report on "The Sackville Medical Centre" by Dr. C. L. Gass, founder of the Centre, who is an ardent proponent of group practice in small towns.

Resolutions

Resolutions were passed expressing the gratitude of the Association to all those who in any way contributed to the success of the meeting. Another was directed to the Prime Minister of Canada to indicate appreciation by the Maritime hospitals of the Dominion Government's recent offer of financial assistance to hospitals. Among other resolutions were the following:

RESOLVED that the Association continue the study and development of grading of hospitals in the Maritime Provinces.

RESOLVED that the Maritime Hospital Association make a special study of opinions relative to the most practical method of caring for those afflicted with chronic and/or incurable diseases requiring hospitalization.

RESOLVED that the incoming Executive be requested to give a more prominent place and longer time to round-table discussion.

RESOLVED that the incoming Executive give study to the possibility of setting up an equalization fund to assist in equalization of travelling expenses of official hospital delegates.

RESOLVED that the incoming Executive give consideration to setting a time limit on the services offered by the Maritime Hospital Association in the interests of a uniform accounting system for hospitals.

Officers Elected

Executive officers elected for the coming year are as follows:

President: Rev. W. J. Gallivan, Port Hawkesbury, N.S.

President-Elect: John N. Flood, Saint John.

Second Vice-President: Rev. Mother Paula, Charlottetown.

Third Vice-President: J. D. Winslow, Woodstock, N.B.

Secretary-Treasurer: Mrs. Gladys Porter, Kentville, N.S.

Additional executive members are:

Nova Scotia: Dr. C. J. W. Beckwith, Halifax.

New Brunswick: Rev. Sister Kenny, Chatham.

Prince Edward Island: Dr. J. A. McMillan, Charlottetown.

—J.F.

Maritime Conference, C.H.A. Meets at St. Andrews

The Maritime Conference of the Catholic Hospital Association met on June 15th, at St. Andrews, N.B., in conjunction with the Maritime Hospital Association Convention. In the absence of Mother St. Theresa, president, Sister Kenny presided. The secretary's report, submitted by Sister St. Joseph, indicated that the organization had gained membership during the past year.

Many interesting papers were presented on a variety of subjects, including administration problems, the training of orderlies, and nursing education. Rev. H. L. Bertrand, president of the Catholic Hospital Council of Canada, gave an address on the "Importance of Ethics for Our Sisters and Nurses from a Catholic Point of View".

Officers elected were as follows:

President: Sister Marion Estelle, North Sydney.

First Vice-President: Sister Veronica, Saint John.

Secretary-Treasurer: to be appointed by the president.

Executive Board: Mother Ignatius, Antigonish; Sister Harquail, Campbellton; Mother Loyola, Charlottetown; Sister St. Joseph, Bathurst; Sister St. Charles, Edmundston; Sister John Baptist, Alberton, P.E.I.; Sister Augustine, Sydney; Sister Leo Marie, Inverness, N.S.

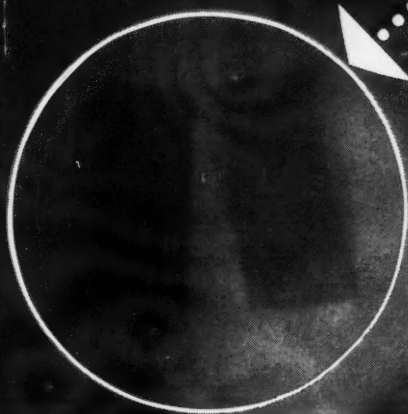


At the Opening of the Victoria General Hospital

Provincial, civic and church leaders attended the opening ceremony of the new Victoria General Hospital, Halifax. Above, left to right: Hon. Angus L. Macdonald, Premier of Nova Scotia; Hon. Frank R. Davis, Minister of Health, who officially opened the building; Dr. C. M. Bethune, Superintendent of the hospital; and Hon. Merrill D. Rawding, Minister of Public Works (speaking).

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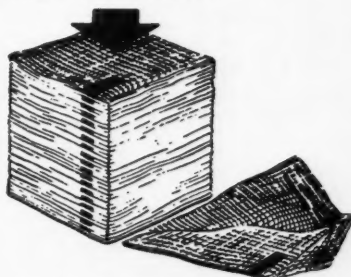


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Food and Its Service

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Association

ANYONE responsible for the service of food, whether it be in the home, school, or residence, commercial establishment, or hospital, is anxious to protect his patrons by serving *safe food*. The public is becoming more conscious of the necessity for safe food service as a means of preventing the spread of colds and other conditions, as well as food poisoning.

This spring, Mr. J. M. MacDonald, Staff Training Officer, Toronto District, Department of Veterans Affairs, in conjunction with the Medical Staff, and Miss Evelyn Creed, District Dietitian, drew up plans for a series of three lectures for dietary staff. These were given at the two large hospitals to all dietary employees in the district. At each centre the employees were divided into four groups and the lectures were given to the same group, at 1.15 p.m. on the same day of each of three weeks. Attendance was compulsory and a record was kept. The time was chosen to include workers from the early and late shifts.

Session I

Introduction

At the first session Mr. MacDonald spoke of the objects of the course and introduced one of the doctors.

Lecture

The subject was "Food Poisoning and Sanitation", in which the doctor stressed the fact that germs were everywhere and also what could happen if incorrect procedures were followed.

Demonstration

The transmission of germs by food was emphasized. Cultures of germs from hands, lips, throat, and table top were made on blood agar plates. The results of these tests were shown at the class the following day so that each group saw the growth of germs.

Posters

Posters made in the occupational therapy department demonstrated correct and incorrect food and dish

handling, and a quiz was given. A glass inverted over a milk bottle, three glasses lifted with fingers inside the glass, two cups of coffee carried one on top of the other, two butter patties one on top of the other, handling spoons by the bowl and forks by the tines, were all quickly chosen as being the incorrect method of the two shown in each case. These simple posters served as reminders to the employee who might have been careless in haste.

Sound Film

A 22-minute sound film "Twixt the Cup and the Lip", prepared by

Report on a Safe Food Service Course

Dorothy E. McNaughton, B.A.,
Chief Dietitian,
Sunnybrook Hospital,
Toronto.

the New York State Health Department and available through the National Film Board, was used. It showed the experiences of a public health inspector and some of the conditions and incorrect procedures he found in various types of eating establishments. It stressed the need for good dishwashing, either by machine or by hand, in each case pointing out that rinse water must be at least 170 degrees. In addition to careful washing, careful handling of clean dishes to keep them sanitized was well demonstrated.

Session II

Lecture

A lecture on personal hygiene was given by one of the doctors who emphasized the importance of thorough washing of hands and care of the

hair, and the need to keep hands clean while serving food. Proper utensils, where at all possible, were recommended for preparation and service.

Demonstration

Two usually clean workers were chosen. One was used to demonstrate a very untidy, dirty worker. She wore a very soiled uniform, and had long flowing hair, through which she ran her hand from time to time; flowers in her hair, large rings and bracelet, long earrings, and excess makeup helped to stress the incorrect dress. Chewing gum, smoking, and the use of a towel to mop her brow were deplored and attention was drawn to her high sling-heeled shoes. The comparison with the well-dressed employee was very evident, with hair held close to the head by a net, clean uniform and towel, and comfortable shoes. In the case of the man, old shoes worn over at the heels, and tied with a string or pieces of ticking, socks down at the ankle, very soiled uniform and unkempt hair were a contrast to the usual clean white uniform.

Posters

Posters were used again to draw additional attention to correct and incorrect dress and an employee was asked to choose the correct features of dress and tell why.

Sound Film

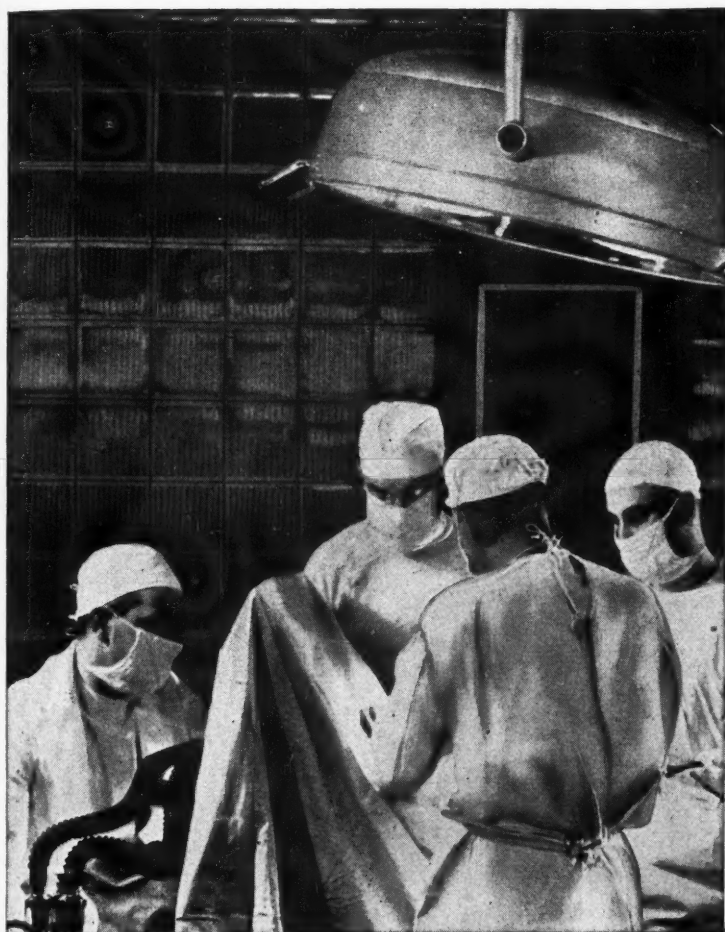
A 20-minute sound film strip, "Safe Food for Good Health", obtained from the Health League, pictured good receiving, storing, preparation, cooking and serving practices. As a comparison, a kitchen with dirt, roaches, rats, and mice was shown on the film.

Session III

Lecture

In this lecture the District Dietitian summed up the other two lectures, stressing as many as possible of the important points, and related these to food preparation and service. Proper handling of soiled dishes was shown to be a protection for the employees' health as well as that of

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others. Attention was drawn to the fact that in the act of smoking it is almost impossible to keep the fingers from coming into contact with the lips and fingers, as well as the ashes which result from smoking, make this a most important "don't". Mr. MacDonald added a most practical point when he related that in his own experience he found he could not smoke and bowl, as infected lips resulted after handling the soiled bowls.

Sound Film

The third film, a coloured one entitled, "Hashslingin' to Food Handling", 24 minutes running time, made in Texas and available through

the National Film Board, is an excellent one from the service point of view. It gave a very impressive comparison of correct and incorrect dress, actions, dish and food handling. The path of germs from an infected customer to the waitress and back to an unsuspecting patron was vividly shown by dark colouring matter.

Quiz

After each lecture, a short question period brought forth interesting queries. A series of eleven questions with two or three answers for each from which the employee was to choose the correct one, and a set of 16 questions to be answered "yes"

or "no" formed the basis for a very lively quiz period. It was found that all employees had secured at least 20 marks out of a possible 27.

Results

The employees showed much interest in the series and those responsible for their work appreciated the course planned by Miss Creed and Mr. MacDonald. A course based on this suggested outline is well worth the effort one has to put into it.

Copies of the papers given at each of the three lectures may be obtained by applying to Mr. J. M. MacDonald, Staff Training Officer, Toronto District, Department of Veterans Affairs, 55 York Street, Toronto.

The Hobby Corner

2: John R. Ross, M.D.



ONE of the large number of physicians who have made painting a hobby, Dr. John Ross, director of the Allergy Clinic at the Hospital for Sick Children, Toronto, achieved considerable fame last year by winning a Second Prize (\$1,000) in the special contest of the American Physicians Art Association for works of art depicting "courage and devotion beyond the call of duty" in the civilian or military life of a physician. Dr. Ross's prize-winning picture of the last moments of Sir Frederick Banting ministering to his injured pilot in the Newfoundland hinterland is shown here; unfortunately this reproduction does not reveal the actual colouring.

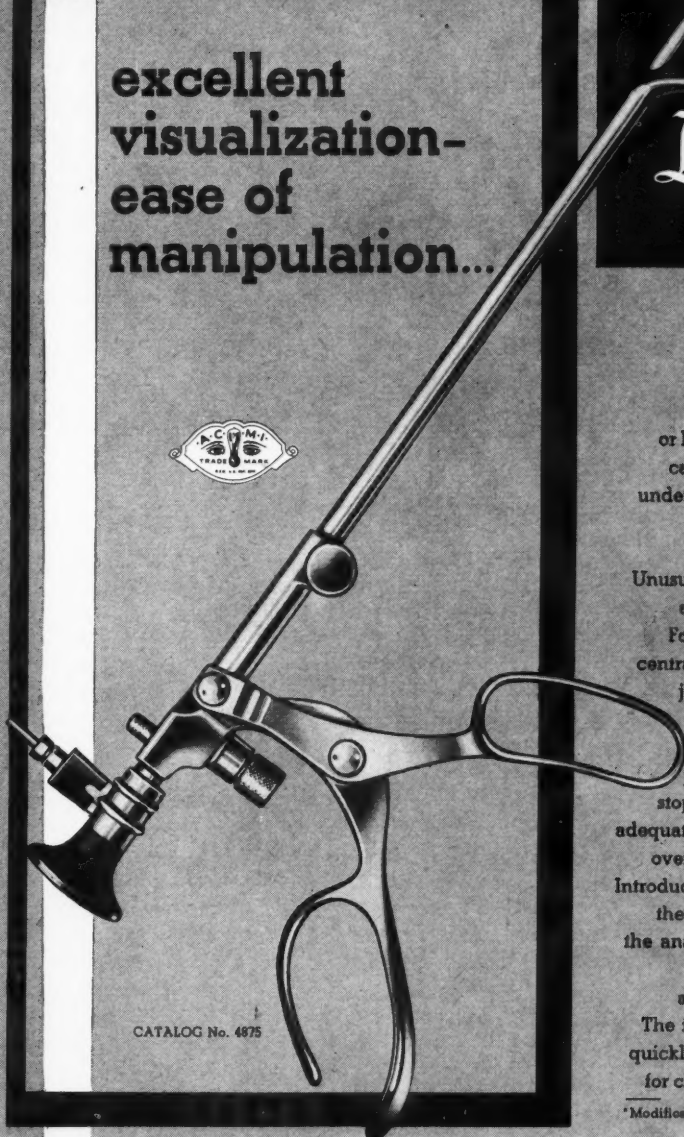
Dr. Ross started to paint during



his undergraduate days, joining an outdoor sketch group under Fred S. Haines and the evening sketch class at Hart House. More recently he joined with others in organizing a sketching group under the guidance of William Winter. His works have been reproduced in *Parergon*. For

the benefit of those modest amateurs who are quite certain that their own attempts are too poor to warrant display, it may be noted that Dr. Ross was very reluctant to send the above "unfinished" study to Atlantic City, and did so only after urgent exhortation by some of his friends.

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C. E. A. Bedwell

Dear Mr. Editor:

Strictly medical subjects are as a general rule outside the scope of these letters. An exception must be made in favour of pathology for two reasons. First, because of its importance in the reorganization of the national health service and, secondly, because the development of the country's pathological service owes much to a Canadian.

The Committee on Medical Schools under the chairmanship of Sir William Goodenough, which reported in 1944, had an important section on the subject of pathology, which forms the basis of these observations. At the outbreak of the war well-staffed and well-equipped laboratories were established, under the auspices of the Ministry of Health and the Medical Research Council, at suitable places throughout the country for the bacteriological control of epidemic disease. The pathological laboratories of some of the London teaching hospitals were removed from the central area of London to places in the sector assigned to them. In connection with the emergency hospital scheme the Ministry had a plan to provide a co-ordinated pathological service for the whole country by establishing laboratories in places where they were most needed and linking laboratories in the small towns to those of the nearest medical teaching centre. For a time there was, in fact, a state pathological service in the strict sense. It is significant and deserving of note in connection with statements which have been made lately that this pathological service did not develop into a general medical service but that the pathologists reverted to their former status and to payment by their former employing authorities.

The development of a pathological service within the Emergency Hospital Service was largely made pos-

sible by the preliminary work which had been done previously under voluntary auspices especially outside London. A prime mover has been Dr. S. C. Dyke, who came from British Columbia as a Rhodes Scholar in 1910, after having been at the University of Toronto and having some experience as a journalist. In 1924 he became attached to the Wolverhampton and Staffordshire General, now the Royal Hospital. On the staffs of provincial hospitals, he

The Status of Pathological Services

found kindred spirits who combined with him to form the Association of Clinical Pathologists. In connection with a coming of age celebration he delivered an address giving full particulars of its development. (*The Lancet*, 3 April 1948).

Pathology has no attraction for the patient in the same way as radiology. The latter may always provide him with a picture even if he does not understand its meaning. Similarly it has no attraction for the supporters of the hospital. As Dr. Dyke well expresses it "as a lure for contribution it could not compete with the operating theatre, and simply was not in the same class as a home, or even a swimming bath for nurses". The result of this lack of funds was that the committees of voluntary hospitals tended to think that the departments should run on a self supporting basis. On the other hand, the pathologist may like to feel that he is independent and, provided he pays the nominal cost to the hospital of materials and accommodation by allocating one-third of the fees to the hospital, can do what he likes with the remainder even when the hospital pays his salary.

The association founded by Dr. Dyke set forth as its primary aims,

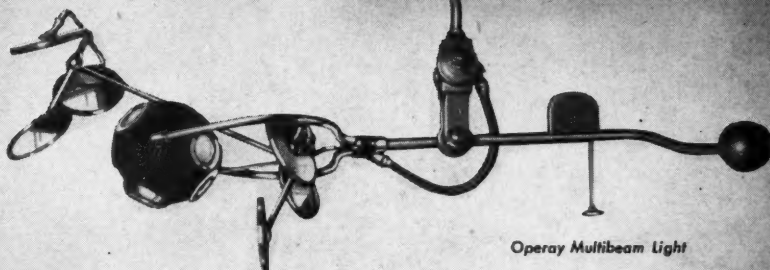
(1) to better the conditions of pathological practice and to improve the status of clinical pathologists; (2) to secure recognition of clinical pathologists on the same level as consultants in other branches of medicine. The progress which has been made in both those directions during the life of the Association has been remarkable. We are a long way from the time when the needs were thought to be met by various agencies, commercial and governmental, through a postal service. The principle formulated in the early days of the Association was that clinical pathology can only be properly practised in laboratories attached to hospitals and by those in close and continuing touch with clinical work. This principle was adopted in the pathological service of the Emergency Hospital Service.

The Association of Clinical Pathologists was also active in promoting steps for the teaching of pathology by persuading the University of London to institute a Diploma in Clinical Pathology and to recognize certain laboratories for the purposes of the Diploma. Dr. Dyke's laboratory was the first to receive that recognition. The Association in appreciation of his services have established a lectureship of which the holder will be given a bronze medal bearing a portrait of his head.

The developments of the national health service which are now taking place include a further advance in the status of pathology, by its recognition in connection with teaching, so that on the medical school authorities, rather than on the hospital, lies the onus of securing its effective organization. The Goodenough Committee came to the conclusion "that in every teaching centre there should be a division of pathology made up of the following four departments—morbid anatomy, bacteriology (including parasitology), chemical pathology and clinical pathology". The aim is to relate as far as possible the teaching of the subject to the rest of the curriculum.

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The Federal Grants-in-Aid

SINCE the publication of the initial announcements respecting the federal grants-in-aid for hospital construction, for personnel training, for research, and for a wide range of public health activities, in our June issue (page 27), various details have been clarified and certain developments have taken place. The Dominion Council of Health, representing largely the various departments of health, met in Ottawa on June 7th and 8th to hear more details of the proposal. As the provincial representatives were there to get information rather than to take action, we understand that progress was somewhat limited in setting up organizational machinery to carry out the many projects indicated; this is understandable and subsequent meetings may reveal a great deal of progress. At the time of writing most of the provinces have already indicated their willingness to participate.

Building grants would seem to be dependent upon the inclusion of the particular expansion proposal in the provincial over-all program to be submitted to the federal government, and in the willingness of the province to match the federal grant. This provincial over-all program is to be developed out of the initial survey for which \$625,000 is to be divided among the provinces. Each province will be expected to study its present situation with respect to hospital

beds, public health and hospital personnel, and various preventive and public health activities; the needs are to be carefully worked out; a long-range program of hospital expansion and of personnel training may be requested; and details of organization for the setting up of a health insurance plan may be required. It is anticipated that these studies will take many months, although some provinces are well on with their "master plans" now. The money available would seem quite adequate, but the problem will be to get competent and well-informed personnel willing and able to leave their present work to make these surveys. Because of the limited number of people who combine a knowledge of survey methods with a balanced and informed viewpoint on the developments of a complete health program, it is hoped that a nation-wide committee may be set up to pool the knowledge of experts and to co-ordinate at least the scope and objectives of the various survey programs.

Whether or not construction begun prior to the Prime Minister's address on May 14th will be eligible for assistance has not yet been announced. The Canadian Hospital Council has urged that consideration be given to construction in the initial stages at least. Because the enlarging of our schools of nursing is just about as essential as the creation of

more beds, and must be proceeded with if these new wings are to be opened, the Council has requested that the grant be interpreted to apply as well to new residence accommodation for student nurses.

It is understood that fifty per cent of the half-million dollar grant for personnel training is to be earmarked for the training of hospital personnel. Obviously this \$250,000 per annum would not go far in subsidizing schools of nursing, but it would help materially in providing special training for instructors and supervisors, and would help in the training of other hospital personnel, such as laboratory technicians, x-ray technicians, medical record librarians, social workers, pathologists, and in the holding of institutes for administrators and special groups. Public health leaders are giving considerable thought to the training of workers in the broad field of public health, as for instance, medical health officers, public health nurses, health educators, health program administrators, sanitarians, laboratory workers, et cetera.

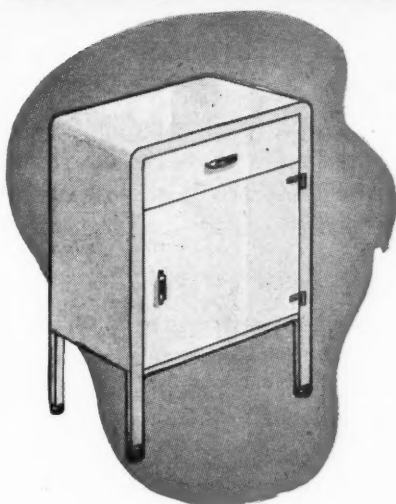
It is very clear that our hospital associations have a busy year ahead of them. Although the major responsibility for working out a comprehensive and long-range program of health care is that of the provinces, it is obvious that the hospitals must be prepared to give the government the best possible advice on a hospital program. Being the first field to be studied, we shall have the least time to prepare sound opinions. It is not enough for each Board to see in this announcement an opportunity to expand its own hospital. What is contemplated is the setting up of a long-range master plan which will locate beds where they are most needed; which will link both large and small hospitals into an integrated pattern; which will include an intelligent program of care for the chronically ill and for the convalescent; which will bring a greater share of our mental care into the field of the general hospital; which will link many aspects of public health with hospital activities; and which will permit a closer relationship between doctors and hospitals. The task requires intensive study by those who can formulate recommendations with vision and without bias.

"... what these expenditures may mean in the preservation of health, in the saving of human life, to say nothing of the lessening of human suffering and misery, and not infrequently despair, is beyond calculation . . .

"A country depleted of its natural resources soon becomes a wilderness, a waste. But of all a nation's resources, its human resources are unquestionably the most precious. The preservation in health and strength of its population is surely the best of all guarantees of a nation's power, of its progress, and of its prosperity. Our greatest national asset is the health and well-being of our people."

—Rt. Hon. W. L. Mackenzie King.

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A REFRIGERATOR to freeze limbs for amputation, installed at Sydney Hospital, Australia, is believed to be the first of its kind in the world. According to the latest report (March 1948) Sydney hospital authorities were seeking temperature recording needles before putting the newly designed refrigerator into operation.

Limbs to be amputated by refrigeration anaesthesia are generally packed in ice and chilled, the

limb often having to be withdrawn while fresh ice is put in. With the new apparatus there will be no need for changing the ice, and temperatures of bones, muscles and skin, will be taken by temperature-recording needles without movement of the limb.

Sydney hospital officials who devised this method of control approached a Sydney philanthropist, Mr. E. J. Hallstrom, a manufacturer of refrigerators, with a suggestion that a refrigerator in which

the temperatures could be controlled would have an advantage over the packed-ice method of chilling limbs. Mr. Hallstrom willingly co-operated and designed an apparatus which he considers to be a satisfactory solution to the difficulties of the ice-pack method. He added an ice chamber to an ordinary type refrigerator. This ice chamber is tunnel-shaped and, after the limb has been placed in it, cotton wool is packed around the entrance.

The refrigerator has been made on the absorption plan, with no moving mechanical parts. It is operated on an electric element and is easily wheeled about the wards.

Refrigeration anaesthesia by ice-pack is used in many countries, mainly for diabetic gangrene, internal disease gangrene, and embolism due to very weak hearts. Patients may be given a sedative (depending upon their nervous condition), but in many cases this is not necessary. The operation is painless, there is no haemorrhaging, and with the present use of penicillin, there is little fear of infection.

The Sydney Hospital is hopeful that the new refrigerator will be so successful that adoption elsewhere will be merited.

By H. W. Sherring, contributed through the courtesy of the Press Attache, Office of the High Commissioner for the Commonwealth of Australia, Ottawa.



Cotton wool is packed around the entrance to keep temperature of leg down to required level.

Neuropsychiatric Disease

It has been estimated that one out of 13 admissions to the medical wards of the general hospital will have a personality disorder which is the explanation of the patient's disabilities. We now know that many cases of acute mental breakdown can be cured with early treatment. For this reason, and because large numbers of persons with incipient nervous or mental illness gain admittance to the general hospital, there is a need for psychiatric services here where accurate diagnosis can be made and cases treated early without publicity. Those unresponsive should, of course, continue to be segregated in lower-cost institutions.

— Abraham Oseroff.



Left: A view of one of the private rooms in the Victoria General Hospital with Metal Craft bed, featuring overbed table and bedside table.



Below: Specially designed to provide for the patient's comfort and convenience in every way possible, this bedside table is a remarkable example of practical planning.



TWO VIEWS show the ingenious arrangement of the various shelves, drawers, basin rack, mirror, etc.

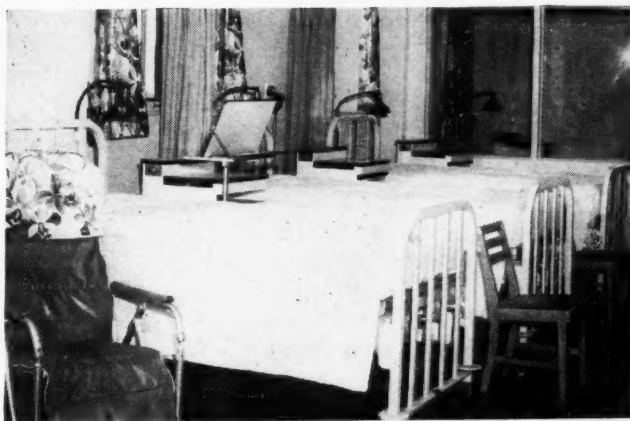
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Above: Semi-private ward showing the individual reading lamps, bedside tables, etc., all planned with the patient's comfort in mind.

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Preliminary Program for Western Institute

THE preliminary program for the Western Canada Institute for Hospital Administrators and Trustees, 1948, has been received. This institute will be held at the Hotel Vancouver, October 4-9, under the general chairmanship of Mr. K. K. Reid. The program committee, under the chairmanship of Mr. George Masters, has worked out a fine program, the highlights of which are as follows:

Monday, October 4

Registration
Greetings
Instructions

George Masters
Kenneth Williamson

Ethics for Hospitals

Harvey Agnew, M.D.

Teaching Responsibilities of Non-teaching Hospitals

G. F. Strong, M.D.

Medical Staff Organization

G. L. Hodgins, M.D.

Special Medical Services

B. J. Harrison, M.D.

Clinical Records

Kenneth Williamson

Anaesthesia Services

Digby Leigh, M.D.

Tuesday, October 5

Nursing Services in Large Hospitals

Sr. John of the Cross

Nursing Services in Small Hospitals

(Mrs. Edith Pringle

The Lay Worker in Hospital Nursing

Mrs. Emily Miles

Hospital Nursing in the Future

Agnes J. MacLeod

Community Hospital Needs

Donald Cox

Hospital Board Responsibilities

A. E. Grauer

Hospital Organization and Management

James A. Hamilton

Round Table

James A. Hamilton

Wednesday, October 6

Accounting Methods

Arthur Hibson

Budget Planning

Arthur Hibson

Uniformity in Accounting

Percy Ward

Round Table

Kenneth Williamson

Employee Relations

A. J. Swanson

The Community and the Hospital

Rev. H. L. Bertrand

Round Table

Harvey Agnew, M.D.

Wednesday Evening

Institute dinner

Rev. Dr. E. D. Braden

Thursday, October 7

Personnel Management

Kenneth Williamson

Recruitment and Selection of Employees

S. N. F. Chant, M.D.

Training of Personnel

O. A. Petersen

Round Table

Donald Cox

In the afternoon visits will be paid to Shaughnessy Hospital, Vancouver General Hospital, Children's Hospital and St. Paul's Hospital.

Friday, October 8

Dietary Organization

Miss M. Northrup

Personnel Relations in the Dietary Department

Wing Comdr. Margaret Clark

Food Service and the Patient

Charlotte Black

Round Table

A. C. McGugan, M.D.

Social Service Administration

Helen Sutherland

Operation of a Hospital Laundry

Speaker to be announced

The Saskatchewan Hospital Plan

G. E. Wride, M.D.

Highlights of the Institute

Harvey Agnew, M.D.

Presentation of Certificates

K. K. Reid

Saturday, October 9

During the morning visits to hospitals will be arranged.

The British Columbia Hospitals Association will meet on Saturday, October 9th.

Further information may be obtained from Mr. Percy Ward, Secretary B.C.H.A., and of the Institute.

Estimated Hospital Expenditures for

Construction and Maintenance, 1947 and 1948

The Department of Reconstruction and Supply, Ottawa, has recently published a booklet entitled *Private and Public Investment in Canada, Outlook 1948*. This is a report of the expenditures expected to be made on new construction, machinery and equipment, and also on repairs and maintenance of structures in Canada in 1948 as compared with 1947. Most of the factual information in this report was obtained from questionnaires circularized by

the Dominion Bureau of Statistics and has been compiled under the direction of Mr. V. J. Macklin and Mr. M. J. Mahoney of the Economic Research Branch of the Department of Reconstruction and Supply.

The following table gives a preliminary estimate of actual hospital expenditures for construction, repair and maintenance in 1947 and a forecast for 1948. The figures represent millions of dollars; e.g., 19.7 means \$19,700,000.

| | Capital Expenditures | | | Repair and Maintenance Expenditures | | | Capital, Repair and Maintenance Expenditures | | |
|------|----------------------|-----------|-----------|-------------------------------------|-----------|-----------|--|-----------|-------|
| | Construction | Equipment | Sub-total | Construction | Equipment | Sub-total | Construction | Equipment | Total |
| 1947 | 19.7 | 4.8 | 24.5 | 4.5 | 2.6 | 7.1 | 24.2 | 7.3 | 31.5 |
| 1948 | 49.2 | 7.6 | 56.8 | 4.8 | 2.6 | 7.4 | 54.0 | 10.2 | 64.2 |

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Titles and Definitions of Nursing Positions

THE Committee on Institutional Nursing of the Canadian Nurses' Association has prepared a list of Titles and Definitions of Institutional Nursing Positions. This list was accepted by the executive committee of the C.N.A. and has been forwarded to the Canadian Hospital Council for approval.

The executive committee of the Canadian Hospital Council has approved these titles and definitions with the understanding that in some hospitals these positions may be combined and that local circumstances might warrant, in some cases, the use of other terms.

Excerpts from Report C.N.A. Committee on Institutional Nursing

"In the past there has been great diversity of interpretation of the various titles designating institutional positions for nurses. To promote effective placement, preparation and functioning of personnel and to avoid confusion in comparing administrative practices of different institutions, it would seem advisable that we agree on certain common titles for nurses' positions in hospitals and that we clearly define them. Greater uniformity in terminology would give both employer and employee a common understanding of what each type of position requires in the way of responsibilities, qualifications and preparations.

"As a first step in assisting institutions in establishing a uniform nomenclature, the Committee on Institutional Nursing selected sixteen titles of positions commonly held by nurses employed in a hospital or school of nursing. In the choice of terminology, we endeavoured to select titles which described the major functions of the position designated. Each title was briefly defined."

Titles and Definitions

Director of nursing and principal of the school

The person responsible for the organization and administration of the nursing service of the hospital and school of nursing.

Director of nursing service

The person responsible for the organization and the administration of the nursing service of the hospital.

Associate director or assistant director

A person who shares all or part of the duties and responsibilities of the director.

Supervisor

One who is responsible for the administration of the nursing service of a clinical department of the hospital, such as medicine, surgery, obstetrics, paediatrics, operating room, out-patient, et cetera, usually composed of two or more units, each under the direction of a head nurse.

Supervisor and instructor in nursing

One who is responsible for the administration of the nursing service and for the classroom and clinical instruction of student nurses in a major department of the hospital such as medicine, surgery, et cetera.

Assistant supervisor

One who shares all or part of the duties and responsibilities of a supervisor of a major clinical department of the hospital.

Head nurse

A nurse who is responsible for the nursing care of the patients and for the management of a unit or ward of the hospital.

Head nurse and instructor in nursing

A nurse who is responsible for the administration of the nursing service in a single unit or ward of the hospital and for the classroom and clinical instruction of student nurses in a particular course such as gynaecology, urology, et cetera.

Head nurse and assistant instructor in nursing

A nurse who is responsible for the administration of the nursing service in a unit or ward of the hospital and for the supervision and instruction of student nurses in that ward or unit.

Assistant head nurse

One who shares all or part of the duties and responsibilities of the head nurse.

General Staff nurse

A nurse who performs nursing service of a general nature in any unit of the hospital.

Special duty nurse

A nurse employed by a private individual or agency for the bedside care of one or more patients.

Instructor in basic sciences

One who teaches biological or physical sciences in a school of nursing.

Instructor in nursing arts

One who teaches the basic principles and practices of nursing.

Clinical instructor

One who is responsible for the classroom and clinical instruction of student nurses in a major area such as surgical nursing, medical nursing, obstetrical nursing, or a sub-division of these.

Assistant clinical instructor

One who shares all or part of the duties and responsibilities of a clinical instructor.

The Committee on Institutional Nursing Recommends:

1. That the titles be used by the National and Provincial Associations in all their relations with hospitals or other organizations.

2. That an effort be made by Provincial Associations to encourage their adoption by hospital staffs.

Distinguished Visitors

Among our visitors at the Council office in recent weeks have been:

Mr. N. Duggan, Senior Surgeon, Worcester Infirmary; Dr. Fred D. Mott, Chairman of the Saskatchewan Health Service Planning Commission, Regina; Mr. Leonard Lockhart, and Mr. M. J. Kirby of Moncton, N.B.; Dr. J. A. Clark of Charlottetown, President of the Maritime Hospital Association. Dr. A. E. Archer, Lamonte, Alta., Consultant on Economics, Canadian Medical Association.

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JULY, 1948

Maritime Hospital Aids Convene at St. Andrews

ON June 14th and 15th some 75 delegates, representing fifty women's aids in the Maritime provinces, gathered at the Algonquin Hotel for their fourth annual convention. The meeting was held just prior to that of the Maritime Hospital Association enabling delegates to attend the hospital sessions and to take home to other members reports of both meetings.

The aids in the Maritimes are divided into four "zones", i.e., Prince Edward Island, Cape Breton, Nova Scotia and New Brunswick, each under a chairman who is a member of the central executive committee. On Monday separate "zone" meetings were held, and these were followed by an executive meeting in the evening.

The general convention was held on Tuesday under the very capable chairmanship of the president, Mrs. P. N. Woodley of Saint John. She was ably assisted by Mrs. J. B. Doucet, who acted as recording secretary in the absence of Mrs. A. M. Hunter of Halifax. Reports for the

year were presented by the president and secretaries, followed by zone chairmen and delegates. Altogether reports from 43 aids were tabled. These revealed a wealth of original ideas which have been used by the various groups, particularly in raising money to assist their hospitals.

Dr. J. A. Clark, President of the M.H.A., addressed the meeting briefly and expressed gratitude, on behalf of the hospitals, for the splendid work being done by the very enterprising aid members in all four zones.

Officers elected for the coming year were:

President: Mrs. P. N. Woodley, Saint John.

First Vice-president: Mrs. Joseph Ross, Truro.

Second Vice-president: Mrs. C. H. Beer, Charlottetown.

Corresponding Secretary: Mrs. J. B. Doucet, Saint John.

Recording Secretary: Mrs. A. M. Hunter, Halifax.

Treasurer: Mrs. H. A. McQuarrie, Westville, N.S.

Zone Chairmen: New Brunswick: Mrs. W. Carson, Moncton; Nova Sco-

tia: Mrs. R. S. McGill, Kentville; Cape Breton: Miss P. J. Connolly, Sydney; and Prince Edward Island: Mrs. J. J. Duffy, Charlottetown.

Magazine Editor: Mrs. W. A. Bel-linger, Sydney.

100 Delegates Attend Conference at Hanover, Ont.

A luncheon, served to about 100 delegates from surrounding towns, opened the district conference of the Hanover Women's Hospital Aids last month. Mrs. W. A. Johnson, president of the Hanover Hospital Auxiliary, presided at the meeting. In an address, Mrs. Graham Harkness, president of the Ontario Aids Association, dealt with the possibilities for service and the duties of hospital aids in the community. Miss Anna Kirchner was presented with a life membership certificate and pin by Mrs. Margaret Rhynas, public relations administrator of the Women's Hospital Aids Association of Ontario. Mrs. Rhynas also gave a stimulating address on "Public Relations".

Aids in Saskatchewan

In nearly all the hospitals, except perhaps the larger ones, the linens are purchased and kept in repair by committees of Aid members. This is a task that is never-ending, but is cheerfully undertaken.—Mrs. P. S. Stewart.

Officers Elected at C.M.A. Convention

At the annual convention of the Canadian Medical Association, Dr. William Wagner, Toronto, was named President and Dr. J. F. C. Anderson of Saskatoon, president-elect. The retiring president is Dr. F. G. McGuiness of Winnipeg. Dr. Harris McPhedran of Toronto was elected chairman of the general council, and Dr. D. S. Lewis, Montreal, honorary treasurer for the coming year. Other officers named were: Dr. T. C. Routley, Toronto, general secretary; Dr. H. E. MacDermot, editor; Dr. A. D. Kelley, Toronto, assistant secretary, and Dr. A. E. Archer, Lamont, consultant in medical economics.

In addition nine doctors were made senior members of the association: Dr. W. J. Knox, Kelowna, B.C.; Dr. Willis Merritt, Calgary;

Dr. F. Corbett, Regina; Dr. W. A. Gardner, Winnipeg; Dr. John Oille, Toronto; Dr. James McQueen, Galt; Dr. W. H. Delaney, Quebec City; Dr. L. D. Densmore, Bathurst, N.B.; and Dr. A. F. Miller, Kentville, N.S.

Many Delegates and Guests at Annual C.S.L.T. Convention

The 1948 convention and annual meeting of the Canadian Society of Laboratory Technologists was held on May 21st and 22nd at McMaster University, Hamilton, Ontario.

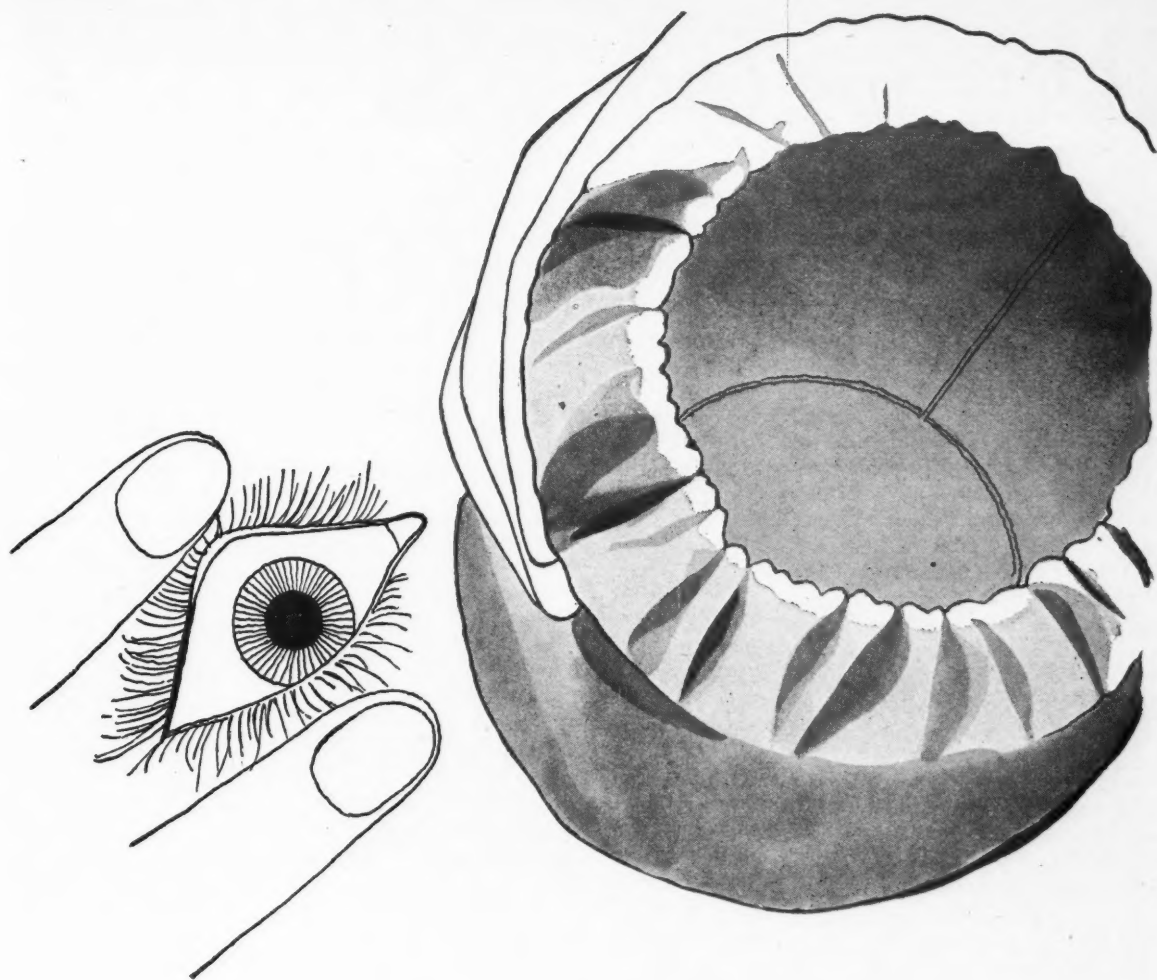
Among the one hundred and eleven members and guests attending the various functions throughout the meeting, were delegates from a number of the provinces, including Saskatchewan and Prince Edward Island. Also present were medical technologists from Detroit and Buffalo, who are registered with the

American Society of Clinical Pathologists.

Some of the medical guests present were: Dr. J. B. Neilson, superintendent of the Hamilton General Hospital; Dr. Jacques Olivier, Director of Laboratories at St. Vincent de Paul Hospital, Sherbrooke, Quebec, one of the approved schools for training medical technologists in Canada; Dr. E. M. Watson, Director of Laboratories, Victoria Hospital, London, Ontario, and Dr. Harvey Agnew, Toronto.

Mayor Samuel Lawrence welcomed the guests at the banquet and the guest speaker was Dr. H. G. Thode, professor of physical chemistry at McMaster University, who gave an interesting talk on radioactive isotopes and their health hazards.

Officers elected include Miss Ileen Kemp, president, and Miss Helen L. Smith, Hamilton, secretary.



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Here and There

An Admirable Hospital of the Thirteenth Century

AN excellent idea of the high standard which hospital building and organization reached by the end of the thirteenth century, will be obtained from a description of a hospital built at this time. The founder of the hospital was Marguerite of Bourgogne, the sister of St. Louis, that is, of King Louis IX of France. Her hospital was erected at Tonerre at the beginning of the last decade of the thirteenth century, and therefore had the advantage of all the experience that had been gained in the hospital movement of that century. It was a very beautiful hospital, as might have been expected at a time when the great Gothic cathedrals, the monasteries and guild halls, which are now the subject of so much admiration, were being built throughout Europe. How it filled the requirements of a modern hospital may be best appreciated from what a modern architect, Mr. Arthur Dillon, has to say about it:

"It was an admirable hospital in every way, and it is doubtful if we today surpass it. It was isolated, the ward was separated from the other buildings; it had the advantage we often lose, of being but one storey high, and more space was given to each patient than we now afford.

"The ventilation by the great windows and ventilators in the ceiling was excellent; it was cheerfully lighted, and the arrangement of the gallery shielded the patients from dazzling light, and from draughts from the windows and afforded an easy means of supervision, while the division by the roofless, low partitions, isolated the sick and obviated the depression that comes from the sight of others in pain . . .

The situation of the hospital might well be thought ideal. It was situated between the branches of a small stream which undoubtedly tempered the atmosphere in warm weather, and then served to carry off much undesirable material, which could thus be disposed of easily. The princess herself dwelt in the hospital, and as she delighted in flowers and had gardens about her lodging, the sick had the benefit of the most grateful surroundings.

The hospital ward itself was fifty-five feet wide and two hundred and seventy feet long, and it had a high arched ceiling of wood. It was lighted by large pointed windows high up in the walls; the height of the windows prevented draughts, and at the level of the window-sills, some twelve feet from the floor, a narrow gallery ran along the wall from which the ventilation through the windows might be regulated and on which the convalescent patients might walk or be seated in the sunshine. The beds were placed each in a shut-in space, open at the top, formed by low partitions that could be moved. Privacy was thus secured much better than in a hospital ward, and as there were only forty beds the ventilation was abundant.

The kitchen and the houses for the store of provisions were in *separate buildings*, and there were also separate lodgings for the monks and the nuns in charge of the sick, for both sexes nursed in the hospital . . .

A feature that perhaps we would not admire so much was that adjacent to the buildings there was a cemetery. They were not so fearful about death in the Middle Ages as we are apt to be. Who shall say that the contemplation of it did not often give that restful sense of submission to whatever would come that sometimes means so much in serious illness, and keeps the patient from still further

exhausting vitality by worry as to the outcome? When Brehmer began to treat consumptives by feeding and rest in the open air, those who refused to eat used to be told quite frankly that, if they did not eat, they could prepare to die, and nothing aroused them so much to make the effort to take food as this expression. In many a tuberculosis sanatorium in this country, patients who refuse to eat, have been reminded by brother patients that unless they cultivated their appetites there was a "wooden overcoat" waiting for them. The deliberate facing of death is not a bad thing for most people, and while the medicine is stronger than our generation might be able to bear, it must not be forgotten that elegant prescribing had not yet arrived in that period and all medicines were apt to be a little bit more nauseating than they are at the present time.

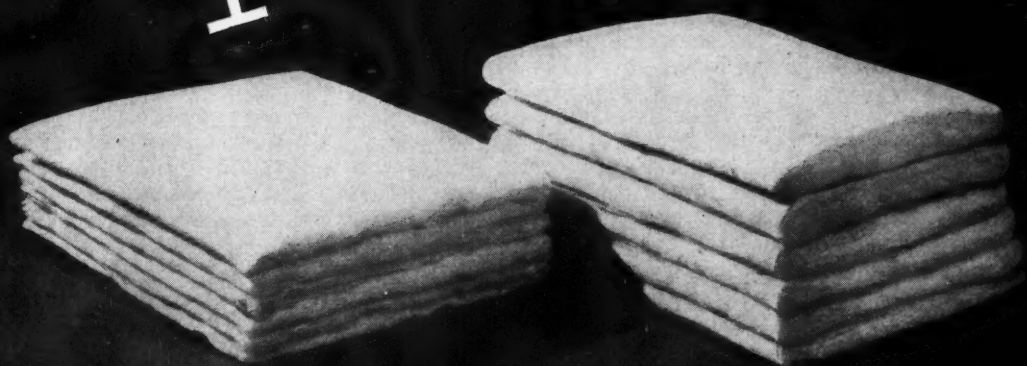
This Modern Age!

Could it be that religion, like most other things to-day, is undergoing fundamental change? Certainly many reprobates would have heaved a sigh of relief could they have heard Father Bertrand, President of the Catholic Hospital Council of Canada, deliver his sermon at morning Mass when the Maritime Conference of the Catholic Hospital Association met in St. Andrews in June.

It may have been the early hour of the seven o'clock Mass; it may have been because Mass was being held in a room that on other occasions would be, obviously, a cocktail lounge (for that week it was dignified by the title "Lower Lounge"); it may have been the broadening influence of being a paratroop padre. At any rate Father Bertrand's selected text had little to do with his eloquent sermon on "Giving", for his startled audience heard him announce as his text the quotation (?), "The Lord Loveth a Cheerful Sinner!"

Excerpt from "The History of Nursing"—James J. Walsh, M.D., Ph.D., published in 1929. P. L. Kenedy & Sons.

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European Hospitals—

Design and Planning

IN an effort to bring to British hospital authorities the newest and best in continental design and planning, the King Edward's Hospital Fund of London has been financing visits to the Continent by representatives of hospitals in the London area.

The first of the reports to be published by the Fund is that of a delegation from Charing Cross Hospital which visited five hospitals in Europe in 1947. The delegates represented the hospital board, the medical staff and the medical school. The hospitals visited were located in Basle, Zurich, Paris and Stockholm. Four of the five hospitals visited were in countries which were not involved in the war, namely, Switzerland and Sweden. Three of the hospitals have been completed quite recently: the Kantonsspital in Zurich in 1945; the Neue Bürgerspital in Basle in the same year and the Söder Hospital in Stockholm in 1944.

The committee brought back a very interesting series of general conclusions and recommendations as a result of this visit. These have been published recently in *The Hospital* (London) for April. Many of the noteworthy details observed in these hospitals are being incorporated in much of the better construction done on this continent. Those recommendations which are either in actual practice here, or are thoroughly recommended are not included in this article. We list below only those points which are either not stressed in recent plans or in discussions before hospital conventions, or are still somewhat controversial. All of the 41 observations made reflect progressive thinking in design and construction.

1. Beauty in every aspect of hospital life is of the first importance, not only in the external aspect of the buildings and in their harmony with their surroundings, but in the size, proportions, light and decoration, of the interior. Simple and

beautifully designed furniture, gay and colourful frescoes and pictures, spotlessly clean uniforms, pleasant gardens, have an incalculable effect on the well-being, not only of the patients, but of the staff and friends.

2. If possible the main administrative rooms of the executive officers should be sited in the body of the hospital in preference to a separate administrative block.

3. To attract labour, the amenities and conditions provided for the staff must meet the needs, the human desires, and the social aspirations of the staff. Thus, really appealing day nurseries, designed for their purpose, should be provided for the children of female day staff; there should be bath and changing rooms for kitchen staff. All suggestions of any social inferiority in domestic work in hospitals should be carefully and tactfully eliminated.

5. Day nurseries where out-patients' children can be left should be provided adjacent to the main out-patient hall.

6. For the patient, one of the most important considerations is the actual bed. This should not only be of the highest degree of comfort but of mobility. The truly mobile bed is one so designed and constructed that one nurse can move it with complete ease. The really mobile bed makes it possible to introduce many features into the hospital life otherwise impracticable. Thus it would enable a feature to be introduced which we all considered to be the greatest single improvement we witnessed on our tour—that is, the elimination of the bed-pan from use in the ward. The bed should be easily moved to an adjacent bed-pan room; if properly designed it can be moved with such ease that nurses in the nature of things prefer to move it rather than to collect screens and carry out the other duties for this trying service in the ward.

8. A further great step forward in the comfort of the patient is to admit

no new patients into the ward after a certain hour in the evening. Patients admitted to hospital after such an hour should be cared for during the night in some other suitable part of the hospital. Maternity patients should be specially provided for in this way.

11. The pain of bereaved relatives may be alleviated by reverent mortuary arrangements. A chapel adjoining the viewing room with opportunity for a religious service with music has a deeply consoling effect and conveys sympathy in a subtle way.

12. There should be facilities in the casualty unit for major as well as for minor operations, for x-ray screening and for simple pathology.

13. It might be profitable to investigate the possibility of so arranging visiting hours in the hospital that large halls and batteries of lifts for visitors could be materially reduced.

14. In our opinion the siting of the main kitchen on the roof has more advantages than disadvantages.

19. The most suitable unit of beds forming a ward under the charge of a single sister seems to be 24 or 25. Within the unit the largest bedroom should contain not more than 8 and not less than 6 beds and there should be a number of single rooms.

24. We are in agreement that the comfort of the out-patient should be carefully studied, and that in waiting halls there should be chairs and tables instead of benches, and a reasonable provision of canteen facilities at certain points.

34. The question whether it may not be cheaper in the long view for a large hospital to generate its own power and use the hot water for space heating is one which, because of the increasing use of power, demands an expert investigation.

38. Excessively large windows in bedrooms seem to us to be undesirable unless (a) they are of the shutter type, giving an open air effect, and (b) are well guarded with sunblinds. In vertical hospitals outside blinds give rise to mechanical difficulties.

39. The question may be raised whether the traditional "southern aspect" of all wards need be so rigidly adhered to. A relaxation of this ancient principle would give much greater flexibility of hospital design and perhaps even some additional comfort to the patient.

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Health Care Plans

Alberta to Provide Voluntary Health Insurance and Hospitalization

An Act to incorporate Medical Services (Alberta) Incorporated was approved at the 1948 session of the Alberta Legislature. The corporation, sponsored by the medical profession of that province, has power to furnish prepaid medical, surgical, and obstetrical care to groups, families and individuals. The initial membership will be limited to groups, and it is hoped that operation of the service will begin at an early date. The corporation will be administered by a board of directors which is representative of both those receiving and giving service.

At the same time, Alberta is establishing the Blue Cross Plan. Associated Hospitals of Alberta was incorporated by a further Act of the 1948 Legislature, receiving power to provide for hospitalization on a prepayment basis and the sole right in the Province to use the words "Blue Cross Plan". This may have been taking over the prerogative of the A.H.A. Blue Cross Commission, but that body has since given approval to the Plan.

* * * *

Staff for Hospital Plan Organized in B.C.

Although actual collections will not be made until 1949, staffs to administer the recently inaugurated, compulsory, contributory hospitalization plan in British Columbia will start work early in September. The main administration office will have a personnel of about 150, with a staff of approximately 45 in the secondary office in Vancouver. Until some of the primary groundwork is laid, complete staffs will not be necessary.

* * * *

Report of Blue Cross Growth

Of the 91 Blue Cross Plans on this continent, the Ontario Plan with 68,924 new members for the first quarter of 1948, was second in enrolment only to New York, which had a net growth of 154,768 mem-

bers. The Ontario Plan has paid two million dollars in subscriber benefits to the hospitals of the province during the first four months of this year. The average payment of \$500,000 per month for this period exceeds by \$200,000 that of the same period for 1947.

* * * *

Ontario Plan Inaugurates New Radio Program

The Ontario Blue Cross, in co-operation with J. Lyons Tea (Canada) Limited, has introduced a radio program featuring a five-minute health hint talk, three times a week for a period of 23 weeks. In order to promote interest in "The Doctor Speaks" the names of three listeners are drawn each week, and these will, after answering a simple question by mail, receive a one year's standard

Regional Hospital Conference Held in Kitchener

The Ontario Regional Hospital Council, Districts 1 and 2, held a conference in Kitchener on May 14th, attended by some 100 persons. An excellent program was provided, starting on Thursday evening, May 13th, with a banquet at which Mr. Everett W. Jones of Chicago was guest speaker.

On Friday, Mr. Horace Atkin, president, opened the meeting. Among the speakers were Miss Jessie M. Wilson, Brantford, who gave an address on personnel problems in the hospital; Miss Priscilla Campbell, Chatham, who outlined the essentials of a good public relations program; Dr. L. O. Bradley, Toronto, who spoke on public health; Miss McDowell, London, who, in her address on nursing problems gave some suggestions for alleviating the nurse shortage; Sister M. Pascall, Sarnia, who stressed the importance of controlling supplies; and Mr. Gordon Friesen, Kitchener, who spoke on hospital economics and presented a plan for integrated services cover-

ward subscription to the Blue Cross, through a special group set up and known as the "J. Lyons (Canada) Limited Radio Group".

* * * *

Large Payments Made Through Blue Cross

A total of \$211,392,885 was paid in 1947 to hospitals by non-profit Blue Cross plans for hospital care of Blue Cross members, according to Paul R. Hawley, M.D., chief executive officer, Blue Cross Commission of the American Hospital Association, co-ordinating agency for 91 Blue Cross plans in the United States and Canada. Payments for members' care in 1947 were \$70,037,936 greater than in 1946, he said.

Total income for all Blue Cross plans in 1947 was \$246,898,312, and 85.62 per cent of that amount went directly to hospitals for services to members.

Dr. Hawley reports that payments to hospitals covered care rendered on a service basis to more than 3,300,000 Blue Cross members.

ing the various hospital departments.

Mr. Everett Jones led a round table discussion on hospital problems. Following this, the delegates were invited on tours to St. Mary's Hospital and the Kitchener-Waterloo Hospital.

Among the officers elected are: Miss Jessie M. Wilson, Brantford, chairman; Rev. Sister M. Pascall, Sarnia, vice-chairman; Mr. R. Ray Copeland, St. Thomas, secretary-treasurer.

Westminster Hospital Superintendent Retires

Dr. Leeming A. Carr, superintendent of Westminster Hospital, London, Ontario, has retired because of ill health. Dr. Carr has been superintendent of Westminster since October, 1945. During World War II, he served overseas with the Canadian Army Medical Corps as commanding officer of the 13th General Field Ambulance Corps. Dr. E. S. Goddard has been appointed acting superintendent.

GEORGE D. FLEMING
MANAGING DIRECTOR



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Personnel Management

FOR a number of reasons it might be supposed that the hospital would be in the forefront of the study and application of the lessons of industrial psychology. On the one hand, in the hospital, more than anywhere else, are to be seen the results, physical and mental, of the stresses and strains of occupational activity, and this might be expected to be an incentive to ensure that occupational activity within the hospital itself did not give rise to similar results. On the other, by the nature and purpose of its activities, the hospital has greater need perhaps than any other enterprise of ensuring that all its services function at maximum efficiency, and accordingly of taking every step to see that all those engaged in the undertaking are enabled to make their maximum contribution, both as individuals and as a team, to its effective working.

In effect any such supposition would be false, and far from being in the lead the hospital is well to the rear in applying the lessons of industrial psychology and especially the principles of modern personnel management. That this should be so is understandable but scarcely justifiable in present circumstances. It is understandable in that the hospital has not the same economic stimulus as the business enterprise to utilize all possible resources, including that of the industrial psychologist, to secure the optimum productivity of its workers, individually and as a whole. Moreover, the number of workers in any one category in the average hospital is not great, and when the numbers working in an office, a stores department, a kitchen, a works department, laundry or other department are small, there is not the same incentive or apparent need to go into questions of working conditions, and still less into questions of selection, training and rating as in the large unit, where the aggregate effect of bad conditions and methods and unsuitable workers shows itself more obviously and is of greater consequence.

Yet merely the circumstance that

the unit or sub-unit is small, or that no question of commercial profit has to be considered, is no reason for not seeking to establish the best possible conditions and routines of work, to select and train the most suitable workers. Whatever the size or nature of the unit the aim clearly should be to utilize all factors of production to the fullest extent. In industry this has long been accepted as axiomatic and increasingly the services of the industrial psychologist, and in particular the tools and techniques of modern personnel management have been utilized to this end. Under the stimulus of two world wars the old paternalistic idea of welfare has given place in industry to a recognition that personnel management is an integral part of the management function, demanding no less attention and study than any other aspect of management.

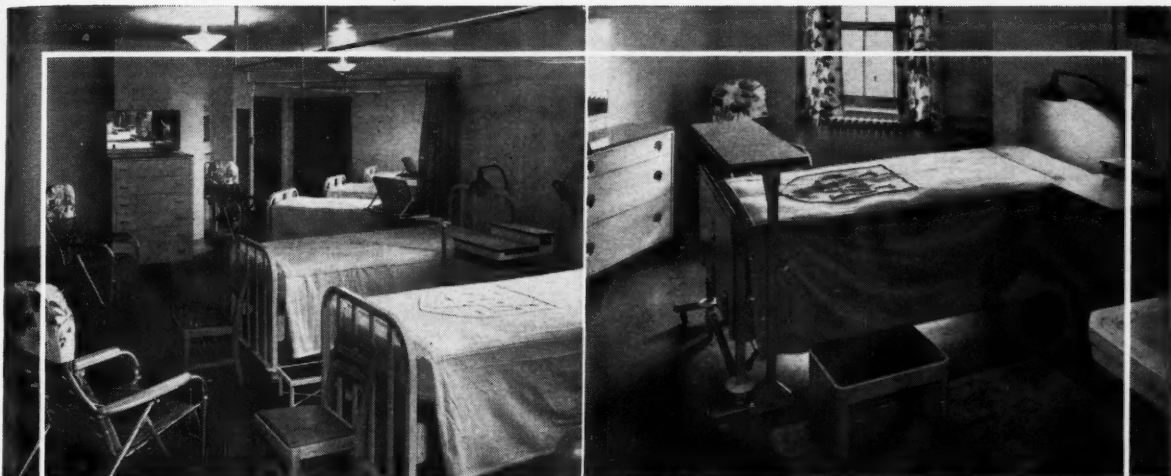
To-day, the hospital can no longer afford to ignore industry's example. The hospital is an institution for the care and treatment of the sick but no less than industrial and commercial organizations it is an employer of labour, and in aggregate a very large one at that. It is true that the hospital has problems peculiar to itself. It must function continuously for twenty-four hours each day and work must be done at the convenience of the patients rather than of the workers concerned. There is an enormous diversity of workers, with innumerable groups of different kinds—administrative, clerical, professional, technical, manual and domestic. There are special problems of professional relationships and, not least, there are also special problems of discipline. Yet, though the hospital has these special problems their existence constitutes all the more reason rather than the reverse for using the tools and applying the principles which other and less complex organizations have found essential to optimum efficiency and well-being.

In the past the hospital may have been able to rely on a combination of a paternalistic conception of welfare on the part of the management

and a sense of vocation and social responsibility on the part of its workers to achieve a satisfactory result. In the circumstances of to-day it can no longer do so. Not merely has the hospital become a larger and more complex unit—a process still continuing—but no less than industry is the hospital faced with scarcity of labour and, therefore, the need to use methods and establish conditions which will on the one hand attract to it the most suitable material and on the other utilize such material to the best advantage. Among other things, in these days, no less than elsewhere, each hospital employee must be convinced that management is cognisant of him and his work and will reward him fairly in accord with his accomplishments. This demands more than mere attention to physical conditions or recognition of the principles of representation and collective bargaining. It demands a positive approach to personnel management and recognition, as in industry, that it is an integral part of management . . .

Where scarcity of hospital workers has been most severely felt—in the field of nursing and domestic work—there has been some recognition of the need for utilizing the lessons of industry. The King's Fund committee, for example, which dealt with the employment of domestic staff in hospitals felt that it had to "bring 'outside' opinions to bear on hospital problems and call in experts to advise on such technical matters as personnel management, economy or dilution of labour, training, supervision and welfare," and in its recommendations the committee suggested the need for a complete and scientific analysis of domestic work in hospitals, with a view to increased efficiency, economy of labour and regrading of personnel. It also proposed that in all but the smallest hospitals a full-time domestic supervisor and welfare worker, responsible for the recruitment, training, supervision and welfare of domestic staff, should be appointed. More recently, in the field of nursing, a similar and even stronger plea for the application of modern principles of personnel management in the hospital has in essence been made by the Working Party in the recruitment and training of nurses. It is to be hoped that these pleas bear fruit.

—From an article in "The Hospital" (London).



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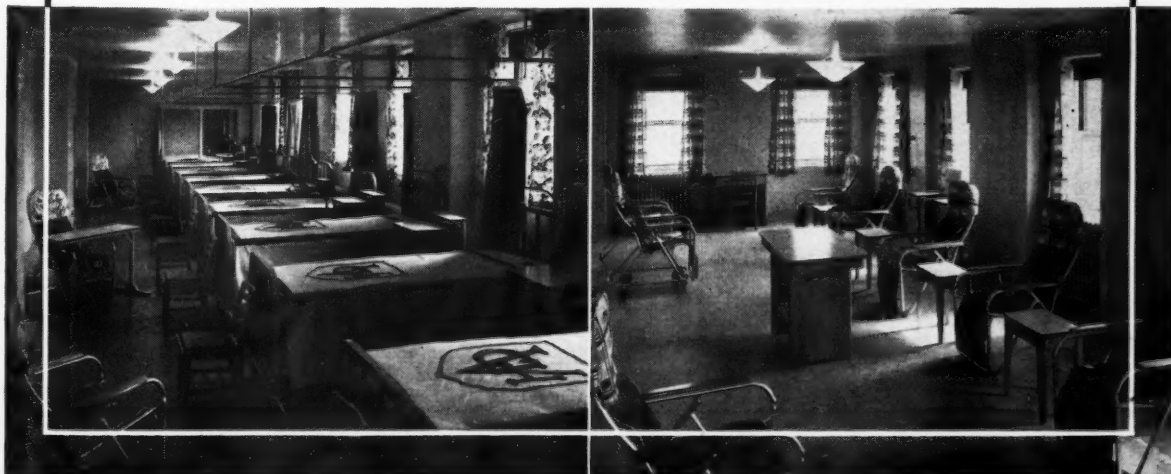
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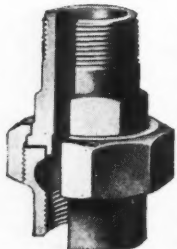
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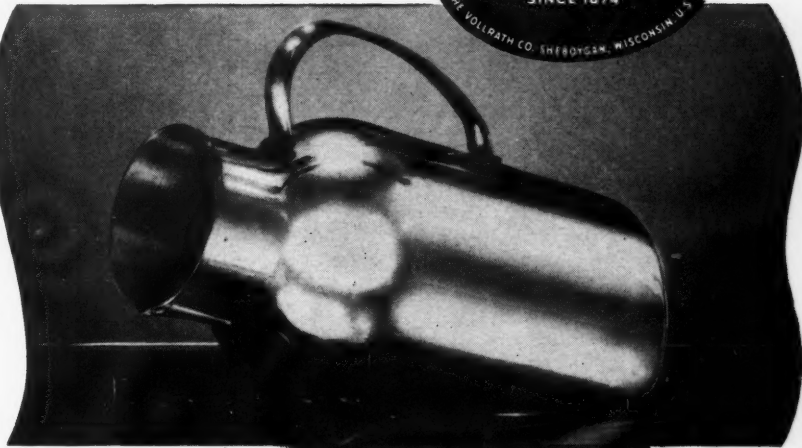
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◀ Provincial Notes ▶

British Columbia

ZEBALLOS. The Nootka Mission Hospital is now enjoying the fruits of a vision of eleven years. An electric power line has been carried from the falls two and one-half miles from the hospital over rough rocks and through dense timberland. It is estimated that the project will save the hospital, school, and other connections hundreds of dollars each year.

Alberta

CALGARY. Dr. Walter S. Quint, radiologist at the Calgary General Hospital, died on April 21st at the Mayo Clinic. Dr. Quint was educated in Toronto and during the second World War served as radiologist at the Colonel Belcher Hospital. He was a Colonel in the R.C.M.C. and commanded the 17th Calgary Field Ambulance.

Saskatchewan

NORQUAY. More than 700 persons attended the official opening of the Norquay-Canora Union Hospital recently. The new hospital will contain nine adult beds, two baby cribs, and four baby bassinets. It will also be equipped with a case room and an operating room for minor operations.

* * * *

NORTH BATTLEFORD. A million-dollar, four-storey brick and concrete extension to the Notre-Dame Hospital is now nearing completion. The extension, sponsored entirely by the community, will augment present capacity of the hospital by 100 beds, and will make available to northwest Saskatchewan the latest achievements in hospital planning and facilities. The provincial department of public health has arranged that a section of one of the floors of the east wing will be rented by health region number 13 for use as a regional health centre.

Manitoba

ALTONA. More than 4,000 persons recently inspected the new Altona hospital, a modern building outfitted with up-to-date equipment and furniture donated largely by local organizations. The staff and patients moved into the new building May 31st, and the official opening took place in June.

* * * *

ETHELBERT. After being closed for five years, due to the shortage of doctors and nurses, the Ethelbert hospital has been re-opened. It is the only medical centre in a one-hundred mile area. Dr. S. C. Henderson, formerly on the staff of St. Boniface Hospital, is in charge.

* * * *

KILLARNEY. The district hospital erected at Killarney was recently opened to the public for inspection, with the official opening to follow in July. Fully equipped with operating rooms, a case room and x-ray facilities, this district hospital is the first to be completed under the new Manitoba Health Plan. The matron is Miss Margaret Kains.

* * * *

PLUM COULEE. Plum Coulee's physician, Dr. Hugh McGavin, was recently honoured for his 46 years of service as the town's only doctor. Mayor Jackman proclaimed a half-holiday in honour of the occasion, and presented Dr. McGavin with a gold watch on behalf of the community.

Ontario

BRAMPTON. Architects are drawing plans for a \$205,000 addition to the Peel Memorial Hospital, which will provide 38 self-contained private and semi-private rooms, 29 cubicles for nursery purposes, and a new laundry and boiler room. It is hoped that the federal and provincial

governments will contribute \$86,000 toward the project.

* * * *

BROCKVILLE. A contract has been placed for the construction of a new boiler room at the Brockville General Hospital. Cost has been estimated at \$26,500, including the smokestack. The building, located just east of the present boiler room, will be of concrete, brick and steel construction.

* * * *

NIPIGON. Overlooking Nipigon Bay stands the new community hospital, a source of pride to the surrounding district which, in conjunction with the Canadian Red Cross Society, fostered and supported it. Costing \$135,000, the building consists of a central section of fireproof stone construction, housing the kitchen, office, and nurses' dining room; adjoining wings are of frame construction, and provide one three bed ward, five private rooms, and six two-bed wards. In addition, there is a sun-porch, x-ray facilities, photography room and a fully-equipped public health wing. The second storey provides eight staff bedrooms and a nurses' sitting-room complete with a stone fireplace.

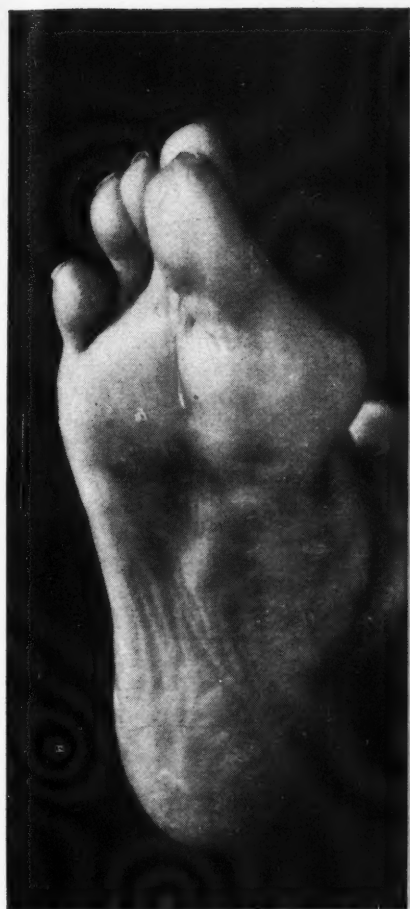
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ST. CATHARINES. The Board of Governors of the St. Catharines General Hospital have announced a \$1,750,000 expansion program, which will increase the present capacity of 182 adult beds and children's cots to a total of 329 beds and cots, and will provide accommodation for isolation cases and for chronic patients. When completed, the hospital will be in a far better position than at present to serve the large area surrounding it. Govan, Ferguson and Lindsay, Toronto architects, have been engaged to prepare initial plans and estimates of cost.

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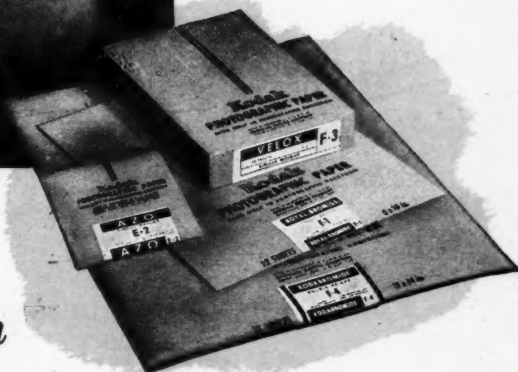
SARNIA. Sarnia General Hospital recently received a capital grant of \$125,000 from the City Council to be used in providing a new power plant and other necessary extensions to the present hospital facilities. A by-law is to be prepared to authorize the raising of the money by debenture issue.

(Continued on page 76)



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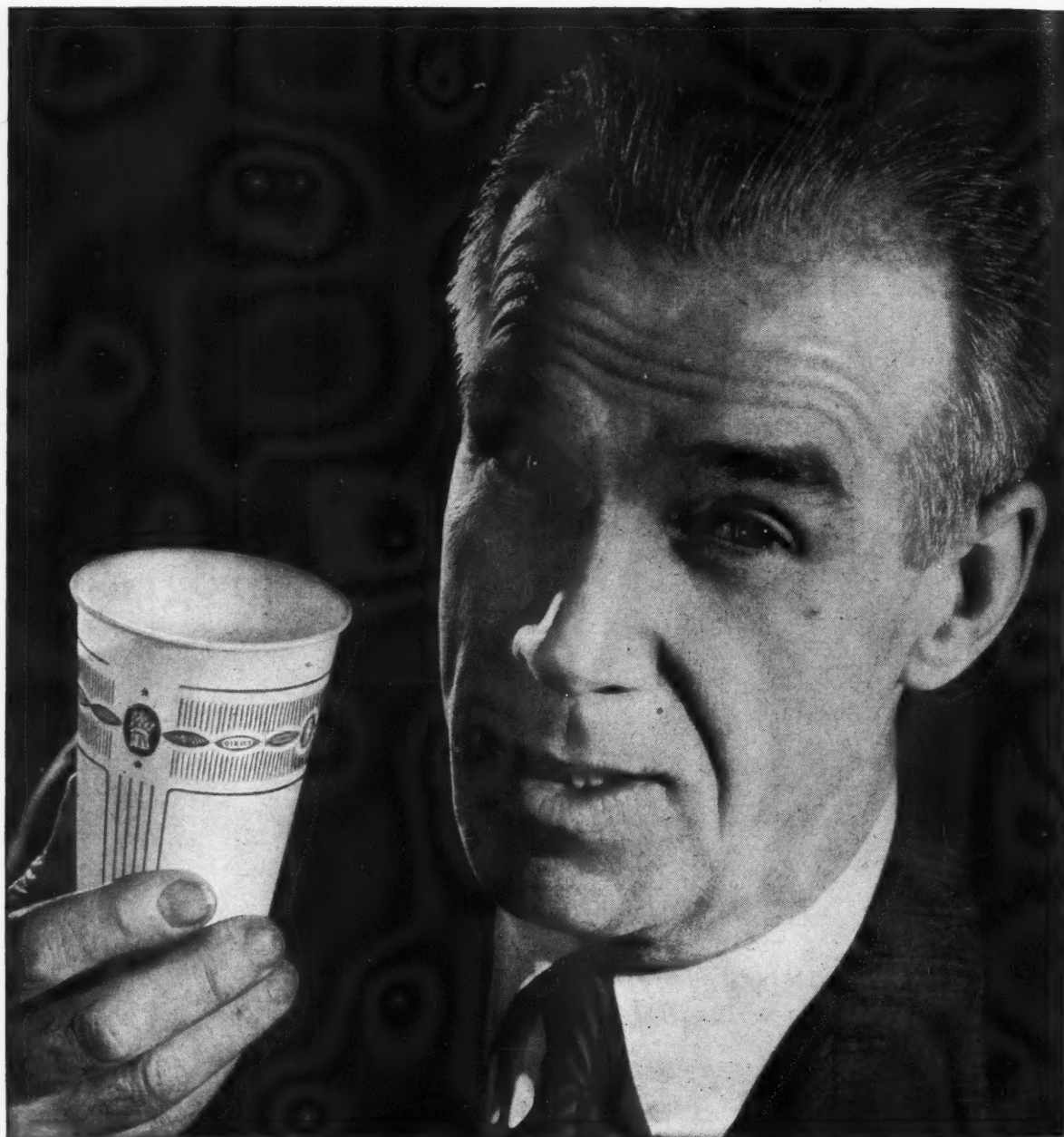
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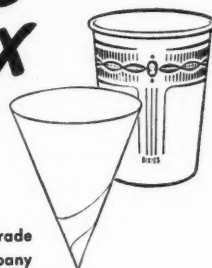
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 - (3) Tonsillectomies
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 - (c) Abscesses
 - (d) Quinsy
 2. Paralysis
 3. Senility
 4. Extreme Mental Deficiency
 5. Obstruction of Esophagus
 - (1) Tumor
 - (2) Stricture (Lye Burns)
- (Strained foods may be incorporated in tube feedings.)

(B) GASTRO-INTESTINAL CONDITIONS

1. Gastric Ulcer
2. Gastric Cancer
3. Gastritis
4. Intestinal Ulcer
5. Enteritis (Colitis)
6. Cholecystitis
7. Diverticulosis
8. Constipation
 - (1) Spastic
 - (2) Mild Atonic
 - (a) Infants
 - (b) Convalescents
9. Vomiting in Pregnancy
10. Cyclic Vomiting
11. Amebic Infections

(C) CASES WHERE BURDEN ON DIGESTIVE SYSTEM SHOULD BE LIGHT

1. Convalescence
 - (1) Febrile Conditions
 - (a) Scarlet Fever
 - (b) Measles
 - (c) Diphtheria
 - (d) Typhoid
 - (e) Undulant Fever
 - (2) Operations
2. Exhaustion
3. Old Age
4. Diseases of Heart
5. Nervous Indigestion

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| C. The Aged | G. Epilepsy |
| D. Pernicious Anemia | H. Pregnancy |

Provincial Notes

(Continued from page 72)

TORONTO. Under construction for four years, the fourteen-million-dollar Sunnybrook D.V.A. Hospital was formally opened last month by the Rt. Hon. Mackenzie King. Before a crowd of hundreds of people, and in the presence of the Lieutenant-Governor of Ontario, of senators, cabinet ministers, and federal, provincial and civic representatives, the Prime Minister of Canada declared the hospital officially opened.

* * * *

TORONTO. Joseph Harris, M.P., chairman of the board of governors, has announced a proposal to expand the Toronto East General and Orthopaedic Hospital to the extent of \$1,500,000. A 25-bed wing is to be included in the building program. A grant of \$150,000 has been made by the City, and a considerable amount has been raised by the hospital through appeals and the efforts of various women's organizations.

* * * *

UXBRIDGE. A public meeting recently approved unanimously the er-

ection of a 20- or 25-bed hospital, at a cost of about \$150,000 which will be raised by public subscription. The new president of the Cottage Hospital executive, Mayor R. J. Harris, remarked that the need for a public hospital was desperate.

Quebec

MONTREAL. Student nurses of St. Mary's Hospital, who up to the present have been housed in the hospital, can look forward to new accommodation in the near future. Construction of a nurses' home, for which a fund of \$195,000 is available, is to commence sometime this summer and, when completed, will give the hospital space for an additional 58 or 60 beds.

* * * *

MONTREAL. Dr. J. E. deBelle, general superintendent of the Children's Memorial Hospital, has announced that construction of a new wing and alterations to the present main section will begin shortly. The

present capacity of 175 beds will be increased to 300, and provision made for a further increase of 500 beds. It is expected that the cost of the project will amount to more than \$1,000,000.

* * * *

MONTREAL. The Quebec Department of Health recently announced that a grant of \$200,000 has been made toward the construction of new wings at the Jewish Hospital of Hope. The president of the hospital board, Jack R. Bogante, remarked that the directors of this non-sectarian hospital, as well as the entire community, were very grateful for this much needed financial aid.

* * * *

MONTREAL. A pleasant and quiet site on Côte des Neiges road between Pine and Cedar Avenues has been procured for a new building which is to replace the present Central Division of the Montreal General Hospital. The modern new hospital will have a bed capacity of approximately 600 public and semi-private beds. The cost of the building, exclusive

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of the site, is estimated at between \$8,000,000 and \$9,000,000. The architect is J. Cecil McDougall, with Dr. Basil C. MacLean of Rochester, N.Y., acting as consultant.

Nova Scotia

HALIFAX. Jack L. Bateman has arrived in Halifax to take up his duties as Administrator of the Children's Hospital. Prior to coming to Canada, he held the post of Assistant Secretary at the Preston Royal Infirmary in England.

* * * *

HALIFAX. Last month the citizens of Halifax took part in a campaign to raise \$275,000 to permit expansion at the Children's Hospital. Among the facilities needed at the institution are a new wing, a new elevator, and modern kitchen equipment.

Need For New Children's Hospital Given Effective Publicity

A campaign was launched this summer in Manitoba to raise \$1,500,000 for the proposed new children's hospital in Winnipeg. A vigorous drive for funds was announced by the chairman of the building drive's general committee. The campaign which included a canvass of all business concerns was given publicity by the local newspapers. One of these ran an arresting, full-page, eye-catching advertisement, giving pertinent details of the old hospital, and leaving no doubt as to the need for a new one. At the top of the page was the sketch of a rather startled baby looking at the old building, under a banner heading in bold face type over an inch high which ran "It is Not Good Enough!" and listed below were the reasons for this statement. The page also contained pictures showing the overcrowded conditions in some of the wards, together with details as to where donations to the fund could be sent.

The chairman of the committee said that the present building, operating since 1911, is totally inadequate for the needs of the growing population of Western Canada. The new building will be located adjacent to the new medical centre near the Winnipeg General Hospital.



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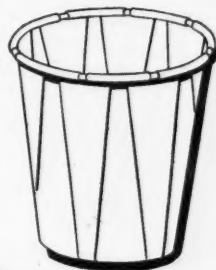
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Henry N. Macneill, M.D.

The hospitals of Manitoba and the Dauphin General Hospital in particular suffered a great loss in the death, on May 12th, of Henry N. Macneill, M.D. Born in the Hebrides and educated in Scotland and England, he had been a resident of Dauphin for more than fifty years. He practised law in that town and was district registrar from 1912 until his retirement in 1938.

His greatest contributions were to education and health. He was a charter member of the Dauphin General Hospital when it was organized in 1901 and was president of the board from 1939 to 1947 when he became life honorary president. He had been a life governor since 1931 and had taken a very active interest in the work of the Manitoba Hospital Association, attending regularly until last year. For many years he was chairman of the Dauphin school board and served on several important commissions to study educational methods. For five years he was president of the Manitoba trustees' association. He was a

life member of the Manitoba educational association. In recognition of his outstanding public service, he was given the honorary degree of Doctor of Laws by the University of Manitoba in 1937. For a number of years he was president of the Dauphin Children's Aid Society and he was also a past president of the Dauphin Canadian Club.

Educational Film Available For Student Nurses

A new 16 mm. technicolour sound film, "The Story of Menstruation", was shown at the recent Ontario Educational Association convention in Toronto. Those present were enthusiastic in their praise, and expressed their genuine appreciation for this valuable teaching aid. The film, which was checked at all stages for medical detail and terminology by prominent gynaecologists, should be of great value in the education of young student nurses.

The film has a running time of ten minutes, and is offered to schools

across Canada on a temporary loan basis. Application should be made to Miss Eva Marsh, Educational Director of Canadian Cellucotton Products Company Limited, 330 University Avenue, Toronto 1, Ontario.

Hospital to Get \$85,000 Balance of Penny Banks

The Toronto Hospital for Sick Children stands to receive about \$85,000 after the Penny Bank of Ontario winds up its affairs next October. R. W. Mayhew, parliamentary assistant to the minister of finance, gave this estimate when the House of Commons gave final passage to a bill repealing the Penny Bank Act.

Practically no business has been done since 1942, when children were encouraged to put their pennies into war savings, and dissolution of the bank, which served Ontario school children for over 40 years, was requested by the directors. The hospital is to get whatever funds are left when the bank has satisfied its depositors and met all liabilities.

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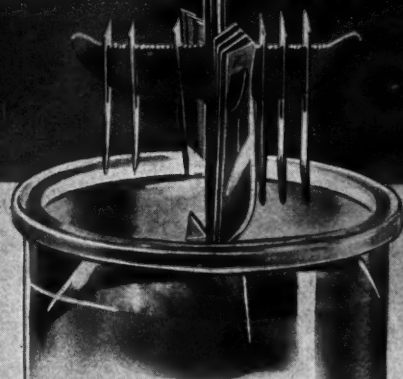
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Psychosomatic Principles

(Continued from page 28)

tempt was made through group activity to restore physical function, confidence and interest by the employment of physical, occupational, recreational and social activities. To carry out such a program in a satisfactory manner the general requirements are:

1. An *integrated service* in which the following participate:

(a) Medical and surgical staff—to evaluate the physical status of the patient and to make recommendations as to physical treatment and activities required, with progressive modification as physical function improves;

(b) Psychiatric or psychiatrically-trained staff—to evaluate personality factors, to give psychotherapy as required and to make recommendations as to other relevant treatment;

(c) An active social service department conversant with the relationship of environmental factors to health and capable of gaining the co-operation of relatives, employers and others in aiding in the rehabilitation of the patient;

(d) An occupational therapy department with a variety of facilities and a capacity for adapting the facilities to the individual's needs;

(e) A physiotherapy department.

2. An *active educational program* for interns and nurses so that all staff will be aware of its purpose and able to contribute to it. The efficient functioning of such a program depends on the close co-operation of the various departments and may be facilitated by interdepartmental conferences and staff rounds.

A brief reference to a new departure in the treatment of psychosomatic conditions is in order, namely, the *day care plan*, described by Dr. D. Ewen Cameron in *Modern Hospital*, September, 1947. This plan is feasible in any hospital which has the facilities already described.

Psychiatric Service

We now come back to the first objective mentioned: the care and treatment of the delirious patient, or of the non-delirious with significant emotional disturbance. This may seem a little more practicable for it can be carried on with a mini-

mum of facilities although the effectiveness of treatment is greatly enhanced by the provision of suitable activities as described above.

It seems that, for the time being at least, the initiative in treating cases from the psychosomatic point of view will rest largely with the psychiatric service. In time this will be a general medical rather than a specifically psychiatric perspective. Until the general medical man gains more confidence in dealing with the delirious or emotionally disturbed patient, or until the supply of psychiatrists is greatly increased, it may well be that the general hospital will continue to have great difficulty in managing such patients and great reluctance in doing so. However, in the future more adequate training of medical students and nurses should make it possible to provide better care for these patients in the general hospital.

Care in General Hospitals

The question of where the psychiatric patient should be cared for in the general hospital is answered in different ways. Most hospitals have

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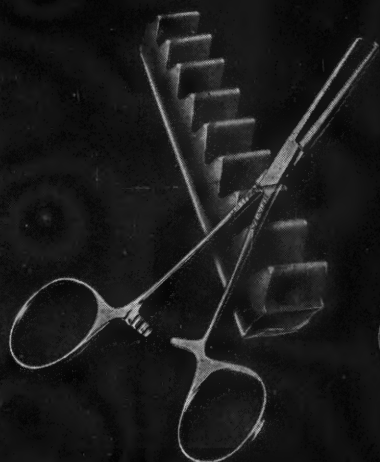
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no psychiatric wards or beds allocated for psychiatric purposes. Some hospitals have established special wards, in some cases open, in others closed. Other hospitals have separate units or buildings for the psychiatric service. In general it seems desirable that the psychiatric service should be as intimately integrated with the medical service as possible. This is to the mutual advantage of both services. It also has been our experience that there is a considerable advantage in being able to treat persons with psychosomatic disorders on the wards of other services while, at the same time, having a closed ward for patients who require segregation either for their own good or for the comfort of other patients.

The number of beds provided depends on the policy of the hospital. Marshall Shaffer, Chief Officer of Technical Services, Division of Hospital Facilities, U.S. Public Health Services, in the April, 1947, issue of *Hospitals* states "all authorities agree that not less than 10 per cent of the total bed capacity should be for psychiatric services". Norman Brill in *Modern Hospital*, January,

1947, states that 5 per cent of the total bed capacity of the hospital is required for the closed psychiatric ward.

The facilities required on a psychiatric ward are described by Shaffer in the aforementioned article. This description is of a more or less ideal physical set-up for a ward in a large hospital. It is not essential to follow his plan in detail, but it is essential to provide, in addition to the usual hospital facilities, various precautionary measures such as guarded lights, fool-proof electrical facilities, strong screens, locked cupboards, additional treatment facilities for hydrotherapy and electro-shock, and a continuous observation area for the supervision of depressed patients.

In summary it may be said that if the general hospital is to assume the role of a health centre in any comprehensive way, it must aim at treating personality disorders as well as physical disease and must take some interest in the rehabilitation of the patient. It is felt that a program so designed would be, in some cases, an economy in shortening the period of hospitalization, in eliminating un-

necessary expenses of investigation and treatment, and/or in preventing repeated admissions. These economies would partly or perhaps entirely offset additional expenditures for trained staff and facilities. Once set up, a gain in efficiency of the program would be expected by the more extensive training and experience of existing staff.

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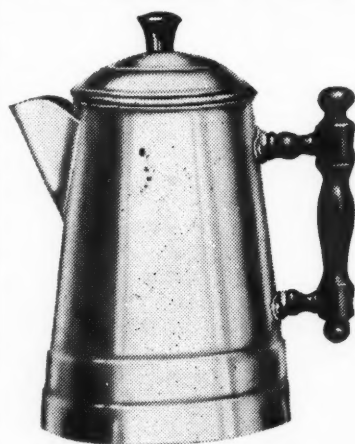
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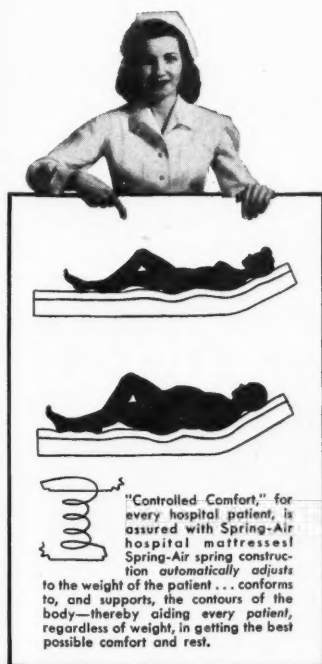
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Pharmacists' Society Organized

The Canadian Society of Hospital Pharmacists, a newly formed society composed of graduate pharmacists as active members, and others interested in hospital pharmacy as associate members, met recently in Toronto to compare notes on common procedures leading to improved methods in that field of work. The organization is now in the nuclear stage and it is hoped that by early next year membership will be increased to cover the whole of Canada and that eventually provincial chapters or branches may be instituted to carry on the regional work.

The aims of the Society, as stated by the president, are: to raise the standard of hospital pharmacy by means of lectures, demonstrations, discussions of problems pertaining to hospital pharmacy, and the interchange of pharmaceutical information; to convince hospital management that the pharmacy department has ceased to be the "drug room" or the "dispensary" but that it is a service unit to the whole hospital; to get pharmacy "out of the basement" and place it in the "service centre"

of the hospital; and to provide hospitals with pharmacists specializing in hospital pharmacy and capable of supervising all of the pharmaceutical activities in both large and small hospitals.

It is the desire of the Society to increase the prestige of hospital pharmacy by making it an important force in the health program of the Canadian people. Although not affiliated, the Canadian organization is patterned after the American society.

The president is Mr. Gordon Smith, Hamilton General Hospital, and the secretary is Miss Irene O. Olynik, Women's College Hospital, Toronto.

Saint François d'Assise

(Suite de page 37)

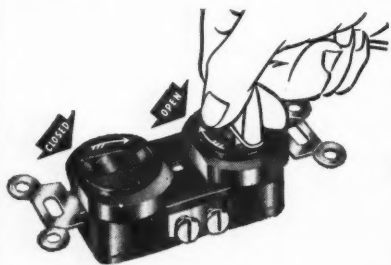
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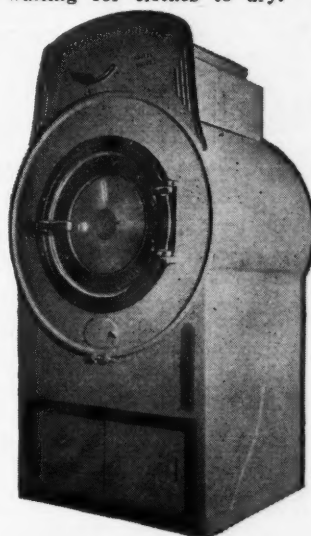
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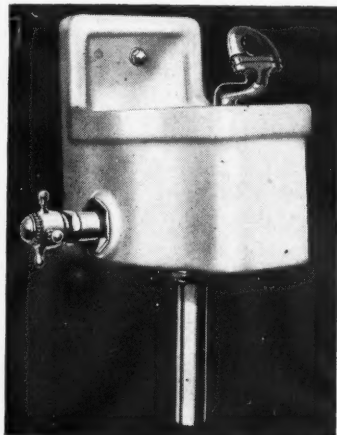


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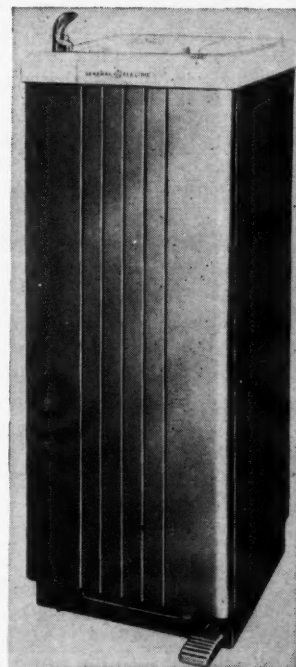
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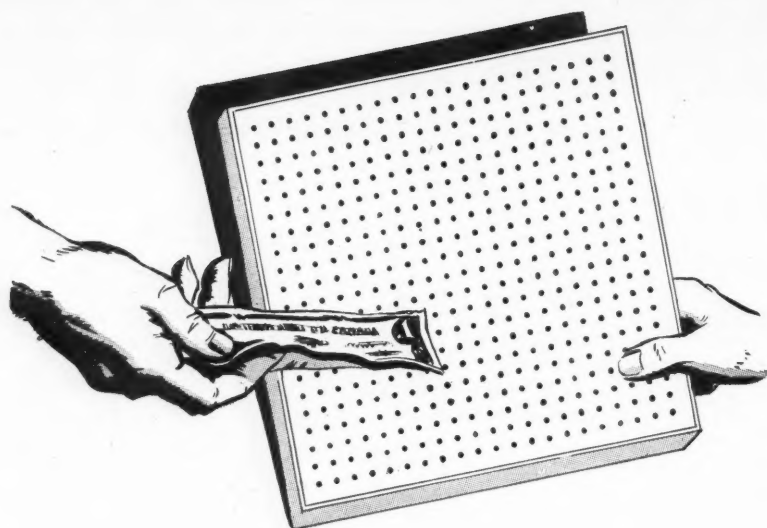
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Correspondence

The Staff Nurse

To the Editor:

I have enjoyed very much reading the article on "Sidelights on Nursing in Rural Hospitals" by Miss Marjorie Gordon of Lacombe, Alberta. (February issue, page 32). One point which I consider important would not seem to be covered in the condensed version as published. In my own studies of many hospitals throughout the United States, it seems to me that the staff nurse in a small hospital has to accept many more responsibilities than the staff nurse in the large hospitals. In the larger institutions a great many of the technical treatments and the responsibilities for observing trends and conditions in the patient's course are taken on by interns, assistant residents, and residents. In the small hospital where there are no house officers and the attending doctors aren't around too much, most of this responsibility falls upon the staff nurse.

It seems to me that the staff nurse in a small hospital should have a better training and educational background than the nurse in the larger institution.

Yours sincerely,

E. W. Jones,

Vice-president,

Modern Hospital Publishing Co.

* * * *

**Western Hospitals Finance
Technicians to Convention**

To the Editor:

The Canadian Society of Laboratory Technologists were fortunate this year in being able to hold both a Regional Western Convention in Regina on May 14, 15 and 16, and also a National Convention in Hamilton on May 20, 21 and 22. The Western Convention was an innovation of last year at which time it was held in Calgary. The idea behind such a venture was to provide technicians in the four western prov-

inces with the opportunities and advantages to be gained from both the scientific program and the value of new contact with fellow technicians, which up till then they had not been able to take advantage of due to the geographical difficulties involved in attending the annual meetings, so far always held in Ontario. They have not only proved the idea sound but have paved the way for taking the National Convention from its traditional Eastern site, further afield both west and east. We hope we may see this accomplished before the dawn of a new decade has been forgotten.

One important thing we have learned from our Western Conventions is the greater interest displayed by hospitals in the West in encouraging their technical staff to keep their professional interest alive by attendance at such sessions. At both of these conventions we have had delegates from Manitoba to British Columbia with expenses paid in full or in part by their hospitals. They appreciate that their investment reaps its reward in better service and keener interest. *In the West such a procedure has become the rule rather than the exception. In the east such a procedure is practically unique.* Is it that the Eastern hospitals are not as awake to the practical value of such encouragement to their technical personnel, or has their lack of interest become a habit?

"Ileen Kemp",
President,
Canadian Society of
Laboratory Technologists.

Enjoyment Out of Doors

The most pleasant of all outward pastimes is to make a petty progress, a merry journey now and then with some good companions: to visit friends, see cities, towns, to walk amongst orchards, gardens, bowers, mounts and arbours, artificial wildernesses, green thickets, arches, groves, lawns, rivulets, fountains and such like pleasant places, brooks, pools, fishponds, betwixt wood and water, in a fair meadow, by a river side, to disport in some pleasant plain, park, run up a steep hill sometimes, or sit in a shady seat must needs be a delectable recreation.—*Anatomy of Melancholy (1621).*

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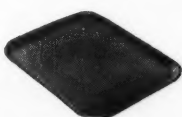
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Human Relations Program

(Continued from page 35)

over. But he would take everything I said too seriously and start taking action on it. He'd pick up the telephone or write memos about what I said, when all I was doing was thinking out loud. So now I don't tell him anything which I don't have to."

The line of authority is only one channel of communication. Information flows sideways, between different departments and divisions. There is the grapevine which carries a mass of fact and fiction in rest periods and lunch hours. Very often there will be a "jungle drum" to warn of impending dangers, such as the arrival of "big shots" in the department.

It may seem that I have painted a gloomy picture of how information travels, especially through the line of authority. In fact, however, information does move between levels, jobs *are* done, and top management does maintain authority over those below. But because the

man-boss relationship is often misunderstood, communication may hinder and not help satisfactory performance.

Broader Developments

It would seem advisable for the administrator to keep an eye on developments in society-at-large, and to understand how these developments reflect on people in the work situation. By way of illustration, consider for a moment what is happening to the class structure of our society, and how the trend influences the feelings and attitudes of the people with whom the administrator must deal. There is ample evidence to indicate that our society is becoming increasingly stratified into classes. People do not move up the social ladder as readily as they once did. People at different levels in the class structure live in different communities, read different publications, belong to different clubs, play different games, bring up their children with different values. Each level thinks differently, has different standards of good and

bad, and different hopes and expectations.

As a result, it is no longer possible for a senior executive to assume that people think as he does. There is to-day some food for thought in George Bernard Shaw's warning regarding the Golden Rule. He said, "Don't do unto others as you would have them do unto you, because their tastes may be different." An administrator has the privilege of having his own convictions, but he must constantly ask himself if these are shared by everyone, or if they should be. One of the most common mistakes in this regard is that of assuming that money plays a central role in human motivations. This assumption may be somewhat true in middle class society, but it is much less true among the workers. Incentive schemes based on this supposition often provide little or no incentive.

There are many concepts concerning human behaviour and human relations in work situations which have not been explored adequately. For instance, the follow-

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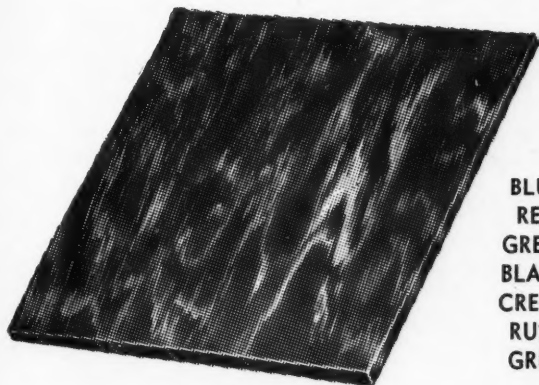
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ing questions about hospitals might be raised. In the hospital setting, just what is the relationship between different groups of people? How do people feel about each other? What effect does hospital employment have on an individual's other relationships in a society? In social gatherings, do people announce with pride or with embarrassment that they work in a hospital? Do hospital employees have a sense of rendering service to the patient? Do certain groups feel a sense of service and others not? How do such things as sickness, accidents, turnover, and absenteeism, relate to people's feelings and attitudes?

Human Relations Research

In the United States research is now in progress which may throw light on such questions as those above. This "human relations research", as it is called, is rather unusual in regard to methodology. The assumption behind this research is that a good way to understand human beings in work situations, is to observe, and pay

careful attention to, what people have to say about themselves, their feelings and attitudes, and their personal and social experiences both inside the hospital and beyond.

This gathering of information does not involve questions and answers centering around a preconceived idea of a problem. The type of interview used is very close to what has been called a "non-directive interview", in which the main aim of the interviewer is to create an atmosphere in which the other person feels free to talk openly about what he considers important and meaningful.

The information gathered is, of course, treated as confidential. When any results are made known, they are generalized and very carefully disguised so that no one person, or no one organization or institution, can be identified.

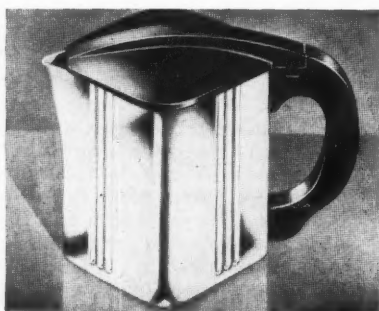
The Institute of Industrial Relations of the University of Toronto is actively engaged at present in three human relations research projects in industrial plants. It is hoped that the Institute of

Industrial Relations, working with the Department of Hospital Administration, will be permitted by the hospitals to commence similar studies in the hospital field in the not too distant future.

My plea is for understanding. One cannot enumerate definite rules which can be adopted to solve personnel problems, because they do not exist. Perhaps such concepts as "social structure", "status" and "communication" are important, and perhaps they are not. It is apparent, however, that still more light could be thrown on the rather complex problems of human behaviour and human relations in work situations.

Harmony in Ourselves

The secret of remaining young in spite of old age and white hairs is to preserve our enthusiasm, and this we can do by means of meditation and goodwill—in short, by maintaining harmony in ourselves. When everything has its proper place in our minds we are able to stand in equilibrium with the rest of the world. —Amiel.



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◀ Book Reviews ▶

OUT OF THIS WORLD. By Dr. Sylvan M. Shane, Director of Anaesthesiology at the South Baltimore General Hospital. Pp. 110. Illustrated. Price \$2.50. 1947. Published by McClelland and Stewart Ltd., 215-219 Victoria Street, Toronto.

Here is a book that should dispel forever the fears and qualms conjured up by one who is anticipating a blessed event, an impacted wisdom tooth, or the removal of an appendix. Written in an intelligent, conversational, and entertaining manner, and illustrated with four excellent photographs, *Out Of This World* is, as the sub-title informs us, "about anaesthetics and what they do to you".

Dr. Shane has chosen to discuss his subject under three headings. The first, "When You Will Be Asleep During the Operation", is an informative description of the use and phenomena of such drugs as ether, gas, and pentothal. "When You Will Be Awake During the Op-

eration" discusses the merits and demerits of local anaesthetics, including spinal injections and novocain. Finally, in "The Romance of Anaesthesia" is the story of the discovery and the evolution of anaesthesia, which in Dr. Shane's own words "is as exciting as a mystery story".

This book will provide, not only an evening of entertaining reading, but one of profit and information.

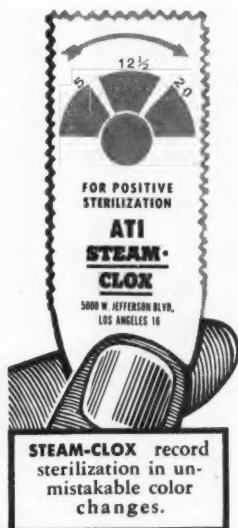
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THE REHABILITATION OF THE PATIENT. By Caroline H. Elledge, Assistant Professor of Social Work in McGill University, Montreal. pp. 112. Price \$3.00. 1948. Published by J. B. Lippincott Company. Canadian address, 2083 Guy St., Montreal.

When so much is being written and spoken about rehabilitation, here is a timely volume which attempts to interpret this subject in terms of methods of accomplishment with particular emphasis upon the role played by the medical social worker. The need for different methods of approach and for varied technics in the solution of the problems encountered by the medical social worker

is illustrated by the use of actual case histories. These histories depict the many types of complex personality problems and the difficult family and social inter-relationships which make up the comedy and tragedy of life. Mrs. Elledge points out that the medical social worker is in a highly strategic position to hunt out these problems and find their solution, and can effectively act as a go-between in calling in the assistance of the various professional experts needed to help solve the problem—the doctor, the technician, the psychologist, the psychiatrist, and the vocational counsellor.

Rehabilitation is a co-operative effort in which the understanding, the knowledge, and the training of doctors and nurses, of psychiatrists and psychologists, of physical and occupational therapists, of social workers and vocational counsellors, must be combined in order to achieve effective and efficient teamwork. It is an aim of this book, then, to point out and stress the important part that the medical social worker can play on this team and in the program of rehabilitation.



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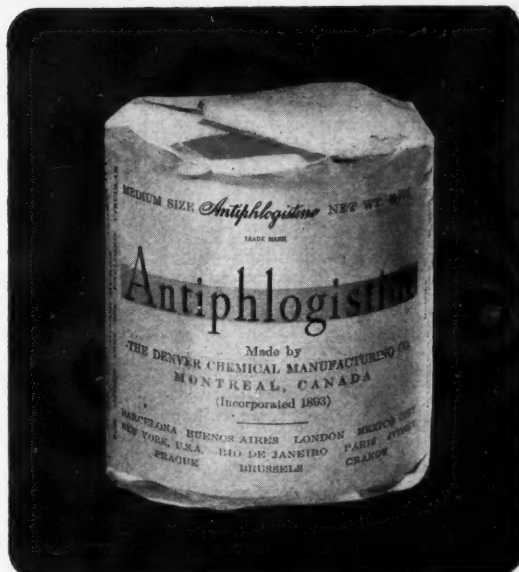
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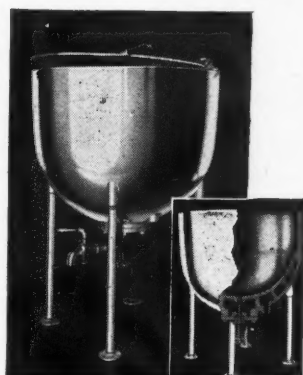


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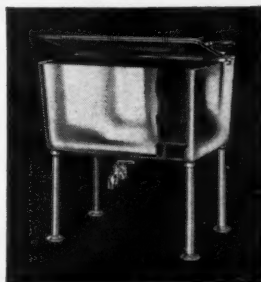


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Admitting Office

(Concluded from page 40)

completing various reports and returns required by the Dominion Bureau of Statistics, Provincial Department of Health, et cetera. Inasmuch as the original information in respect to statistics is recorded by the admitting office, it is desirable that this should be followed through and that the admitting office should take the responsibility for the recording, compilation, and summary, of all statistics relating to admissions, discharges, births, deaths, patient days, and so on.

In cases of deaths in the hospital, as well as looking after the necessary registration, the admitting office may also have the responsibility of trying to secure permission for an autopsy from the next of kin, or at least of putting the next of kin in direct touch with the official charged with the responsibility. This office will also likely be required to see that all deaths are properly recorded, that the bodies are released to undertakers when ready, and that appropriate records of all these occurrences are kept.

In the smaller hospitals, the admitting officer will have other duties which may include the discharging of the patient, keeping of medical records, handling of cash, bookkeeping, et cetera. She may not even be referred to as the admitting officer and she may even run the hospital!

Even in larger institutions with separate specialized facilities, it is altogether likely that the admitting officer on duty after the regular staff

have finished work for the day will have to act in all of these various capacities.

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July 19-23—A.H.A. Institute on Hospital Laundry Management, The Penn-Sheraton Hotel, Philadelphia, Pa.

August 8-23—C.H.A. Institute, Quebec City.

Aug. 23-25—Quebec Conference C.H.A., Quebec City, P.Q.

September 6-18—A.C.H.A. Institute for Hospital Administrators, Chicago.

September 18-19—American College of Hospital Administrators, Traymore Hotel, Atlantic City.

September 20-23—American Hospital Association, Convention Hall, Atlantic City.

Week of Oct. 4th—Western Institute for Hospital Administrators, Hotel Vancouver, Vancouver.

Oct. 14-15—Saskatchewan Hospital Association, Saskatchewan Hotel, Regina.

Oct. 18-22—A.C.S. Clinical Congress, Biltmore Hotel, Los Angeles.

November 1-3—Ontario Hospital Association, Royal York Hotel, Toronto.

November 8-10—Associated Hospitals at Alberta, Palliser Hotel, Calgary.

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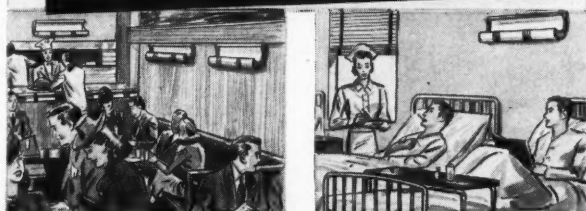
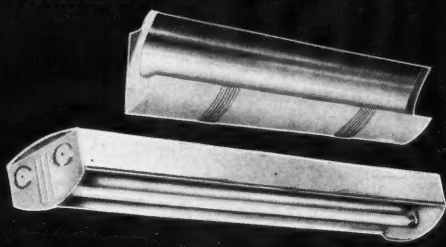
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Canadian Dietetic Association Meets in Montreal

Over 300 persons attended the Canadian Dietetic Association's thirteenth Annual Convention held in Montreal, June 2-4. At the opening luncheon, an official welcome was extended by the mayor of Montreal, Camillien Houde, C.B.E. The three-day program provided for general sessions in the afternoon and evening when a wide variety of informative addresses were presented followed by stimulating discussion periods. As an added interest, opportunity was given to the members to visit the excellent exhibits, and special bus trips were arranged to the Montreal General Hospital Institute for Special Research and Cell Metabolism, to the University of Montreal, and on Saturday to the Laurentian mountains. On Friday the sessions were followed by a banquet at which the guest speaker was John Fisher, well-known CBC reporter and commentator.

The officers for the coming year are as follows:

Hon. President: Violet Ryley, Toronto.

Hon. Vice-President: Marjorie Bell, Halifax.

President: Kathleen Jeffs, Montreal.
President-Elect: Margaret Clark, Ottawa.

Vice-President: Helen Farrell, Montreal.

Secretary: Dorothy Shantz, Montreal.
Treasurer: Elsie Watt, Toronto.

Past President: Dorothy McNaughton, Toronto.

X-Ray Technicians Meet in Quebec

More than a hundred x-ray technicians from all parts of Canada registered at the Chateau Frontenac, Quebec City, for the Sixth Annual Convention of the Canadian Society of Radiological Technicians. On each of the three days of the meeting, June 17, 18 and 19, excellent technical papers were given, and much important executive business was harmoniously disposed of besides. Radiologists Desmond Burke, Toronto, Jules Gosselin, Quebec, and Edward A. Petrie, Saint John, New Brunswick, were welcome representatives of the Canadian Society of Radiologists, and displayed a sympathetic and helpful interest in the problems of the technicians throughout the convention. President H. C. J. Simkins, of Montreal, Vice-President and Secretary-Treasurer Percy

Hunt, Saskatoon, and all the delegates, were unanimous in appreciation of the success of the meeting, and the abounding hospitality shown them. Election of officers for the next term will be held by ballot in September.—P.G.

I know nothing can conduce more to letters than to examine the writings of the Ancients. They opened the gates, and made the way that went before us.

—Ben Johnson.

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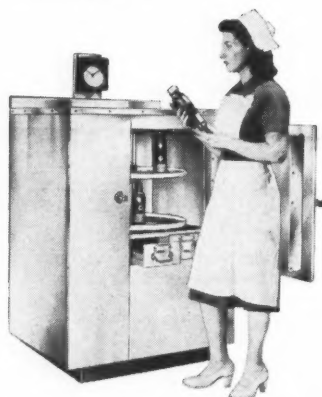
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